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Commonwealth of Kentucky
Department for Medicaid Services
Division of Program Quality and Outcomes

Comprehensive Evaluation Summary of the Commonwealth of Kentucky Strategy for Assessing and Improving the Quality of Managed Care Services

FINAL REPORT
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Introduction

This comprehensive evaluation summary presents an in-depth review of the accountability strategy, monitoring mechanisms and compliance assessment system described in the Commonwealth of Kentucky's Strategy for Assessing and Improving the Quality of Managed Care Services. According to federal regulation (42 CFR§438.200 et seq.)[1], all states that contract with a managed care organization (MCO) or prepaid inpatient health plan (PIHP) are required to have a written strategy for assessing and improving the quality of managed care services provided to Medicaid enrollees.

Authorizing legislation and regulation for state Medicaid managed care (MMC) programs include the Social Security Act (Part 1915[2] and Part 1932(a))[3], the Balanced Budget Act of 1997 and Title 42[4], Part 438 of the Code of Federal Regulations (CFR)[5]. On April 25, 2016, the Centers for Medicare and Medicaid Services (CMS) published the Medicaid and CHIP Managed Care Final Rule[6] in the Federal Register. This final rule, which is the first major update to Medicaid and CHIP managed care regulations in more than a decade, aligns Medicaid rules with those of other health insurance coverage programs, modernizes how states purchase managed care for beneficiaries, and strengthens the consumer experience and consumer protections.

Kentucky's Strategy for Assessing and Improving the Quality of Managed Care Services (also referred to as Kentucky's Quality Strategy) was approved by CMS in September 2012, and includes the following:

- program goals and objectives;
- MCO contract provisions that incorporate the standards of 42 CFR Part 438, subpart D;
- procedures used to regularly monitor and evaluate the MCO's compliance with 42 CFR Part 438, subpart D, including standards for access to care, structure and operations and appropriate use of intermediate sanctions;
- procedures that assess the quality and appropriateness of care and services provided to all Medicaid enrollees in an MCO;
- arrangements for annual, external independent reviews of quality outcomes and timeliness of and access to services;
- procedures for review and update of the strategy;
- procedures to identify race, ethnicity and primary language spoken; and
- an information system that supports ongoing operation and review of the Kentucky's Quality Strategy.

The intent of this Comprehensive Evaluation Summary is to continue the evaluation of Kentucky's Quality Strategy using updated information, reports and interviews conducted during the period July 1, 2015 through June 30, 2016. As part of the introduction, recent developments in Kentucky's MMC Program are discussed including a description of program monitoring responsibilities and evaluation methodology.

Medicaid Managed Care in Kentucky – Recent Progress

In December 1995, the Commonwealth of Kentucky received approval from CMS under Section 1115 waiver authority[7] to establish a statewide MMC program that would be phased into eight different regions of the state over time. The waiver initially established two health care partnerships of medical providers in both public and private sectors providing comprehensive medical services to Medicaid beneficiaries living in two designated regions Region 3 (Jefferson County and 15 surrounding counties) and Region 5 (Fayette County and 20 surrounding counties). In 1999, the Region 5 partnership withdrew from the managed care program and by the fall of 2000, Kentucky stopped plans to implement a statewide risk-based managed care program. The partnership with University Health Care (doing business as Passport Health Plan) continued service in Region 3 and the rest of Kentucky's Medicaid members were enrolled in the fee-for-service (FFS) system.

With increasing Medicaid health care expenditures and a growing eligible population, Kentucky once again turned to risk-based managed care as a solution and in 2011, initiated a procurement process to contract with MCOs to provide services statewide. Three additional MCOs were awarded contracts by July 2011: Coventry Health and Life Insurance Company (doing business as CoventryCares of Kentucky), Kentucky Spirit Health Plan, Inc., and WellCare of Kentucky, Inc. On November 1, 2011, risk-based managed care was implemented.

After a little more than a year, Kentucky Spirit Health Plan notified the Kentucky Department of Medicaid Services (DMS) that they would be withdrawing from the managed care program as of July 2013. The state successfully procured a new contract with Humana-CareSource and the transition of enrollees was underway before the end of 2013. The Patient Protection and Affordable Care Act (ACA) allowed DMS to further expand Medicaid eligibility in 2014 and Kentucky contracted with Anthem Blue Cross and Blue Shield (BCBS) Medicaid to first serve Medicaid expansion members in all regions of the state excluding Region 3 and then included Region 3 in 2015. On May 7, 2013, Aetna acquired Coventry Health Care Inc. resulting in the transition of CoventryCares of Kentucky to Aetna Better Health of Kentucky by February 1, 2016.

Program enrollment grew by 4.8% from 1,174,716, in April 2015 to 1,231,505 in April 2016. Anthem BCBS Medicaid almost doubled its enrollment over the last year, followed by increases in enrollment for Passport Health Plan (14.1%), Humana-CareSource (11.2%) and WellCare of Kentucky (1.0%). Enrollment in Aetna Better Health of Kentucky decreased by 9.1% from April 2015 to April 2016 (Table 1).

Table 1: List of Current Medicaid MCOs by Service Area and Enrollment

MCO	Enrollment 4/2015	Enrollment 4/2016	Percent Change	Service Area
Anthem BCBS Medicaid	69,031	100,849	+46.1%	Statewide
Aetna Better Health of Kentucky	303,686	276,052	-9.1%	Statewide
Humana-CareSource	113,039	125,658	+11.2%	Statewide
Passport Health Plan	251,855	287,255	+14.1%	Statewide
WellCare of Kentucky	437,105	441,691	+1.0%	Statewide
Total	1,174,716	1,231,505	+4.8%	N/A

MCO: managed care organization; BCBS: Blue Cross and Blue Shield; N/A: not applicable

Responsibility for Program Monitoring

DMS of the Kentucky Cabinet for Health and Family Services (CHFS) oversees the Kentucky MMC Program and is responsible for contracting with Medicaid MCOs, monitoring their provision of services according to federal and state regulations and overseeing the state's Quality Strategy as well as each MCO's quality program. DMS contracts with an external quality review organization (EQRO), Island Peer Review Organization (IPRO), to assist the state in conducting external reviews and evaluations of state and MCO quality performance and improvement.

In mid-2013, DMS underwent an internal re-organization to better address its responsibilities for monitoring and oversight of an expanding MMC Program. A new division within DMS, the Division of Program Quality and Outcomes (DPQ&O), was created and consisted of two branches: Disease and Case Management Branch and Managed Care Oversight – Quality Branch. Effective July 1, 2014, the Managed Care Oversight – Contract Management Branch became part of the Division of Program Quality and Outcomes.

During 2015, several changes in leadership occurred. Newly elected Governor Matt Bevin appointed a new cabinet secretary, Vickie Yates Brown Glisson, and a new commissioner to DMS, Stephen Miller. One of the deputy commissioners retired and Veronica Cecil was named deputy commissioner. The medical director position is currently vacant. At the division level, Director Patricia Biggs left DPQ&O, and Cindy Arflack, who was previously deputy director, became the new director. The assistant director position is vacant. A number of staff vacancies also exist including a nurse/consultant inspector position in the Disease and Case Management Branch as well as one internal policy analyst III position in the Contract Compliance Branch.

The Managed Care Oversight – Quality Branch of DPQ&O monitors EQRO progress and reviews findings from all EQRO documents, encounter data summaries, the Healthcare Effectiveness Data and Information Set (HEDIS®) and other quality reports with an eye toward quality improvement. Branch staff updates DPQ&O's web pages with current documents and information; reviews and modifies all MCO reports; creates spreadsheets, reports and dashboards to display and analyze the data; and monitors the EQRO contract for compliance and correct invoicing. With the aid of the

EQRO, the Quality Branch is recently working on performing more in-depth reviews of access and availability issues and performing more case reviews as they relate to access and availability. The Quality Branch is currently participating in several collaborative initiatives including the CMS Tobacco Cessation Affinity Group, the Substance Abuse and Mental Health Services Administration (SAMHSA) Tobacco Policy Group for Kentucky (focusing on provider education) and the CMS Antipsychotic Use in Children Affinity Group. Their efforts with the two smoking groups are aimed at helping to raise quit attempts and to lower the smoking rate in Kentucky. They also continue to work at developing HEDIS-like quality measures for the Kentucky FFS population with Hewlett Packard (HP).

The Managed Care Oversight – Contract Management Branch of DPQ&O is responsible for monitoring contract compliance for the five Kentucky MCOs and reviewing required reports submitted by the MCOs. They continue to intensify their contract compliance efforts and have initiated penalties/withholds for non-compliance and failure to correct after being issued corrective action plans (CAPS) and letters of concern (LOCs).

The Disease and Case Management Branch of DPQ&O responsibilities cover a broad range of monitoring and coordinating functions working closely with the Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID), Department for Aging and Independent Living (DAIL) and the Department of Community-Based Services (DCBS). The Disease and Case management Branch has focused on care coordination and case management referrals for special populations such as medically fragile children, foster care children and adults in guardianship and during this past year have been working more on provider issues related to both grievances and appeals and disenrollment for cause requests. They are also leading the Kentucky group for the CMS Oral Health Affinity Group.

With several leadership changes and increasing branch responsibilities for monitoring and quality improvement, Kentucky continues to vigorously apply staff resources and expertise in the development of their expanding MMC Program, thus providing needed direction and cohesiveness for it moving forward. Although staff continually faces the challenge of achieving more with less, they have enthusiastically applied for and received acceptance to participate in several CMS Affinity Group collaboratives which offer an opportunity to expand state resources through collaboration with other state and national participants. CMS's Medicaid Prevention Learning Network offers state Medicaid programs an opportunity to receive technical assistance and state-to-state learning to promote best practices in preventive health care in Medicaid and Children's Health Insurance Program (CHIP). The Tobacco Cessation Affinity Group focuses on strategies to increase utilization and quality of smoking cessation benefits for Medicaid and CHIP enrollees and aims to reduce tobacco use, improve health, and reduce costs attributable to smoking-related health conditions. The Antipsychotic Drug Use in Children Group supports state efforts to improve quality of care for children prescribed antipsychotic drugs, while the Oral Health Affinity Group provides a forum to share quality improvement practices in oral health care.[8]

All five Kentucky MCOs participate in the CMS Affinity Groups and the SAMHSA Tobacco Policy Group, and all agree that they are valuable learning collaboratives.

Evaluation Methodology

The methodology for this report included a review of documents from external review activities, MCO reports and interviews with staff from IPRO, DMS and each of the five MCOs. Managed care activities and experience from other states' external quality reviews and quality improvement initiatives were researched to provide valuable insight into promising practices for DMS consideration.

This report includes an overview of Kentucky's MMC data reporting systems obtained from MCO and EQRO reports. Quality strategies, obtained from state websites, provided information regarding EQRO activities, performance improvement projects (PIPs) and quality improvement (QI) initiatives from other states. Core program goals from Kentucky's Quality Strategy were quantified and statewide aggregate baseline data were obtained from HEDIS and the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) 2015 results.

EQRO documents reviewed as part of this year's evaluation included the following:

- 2016 External Quality Review Technical Report (April 2016 Draft), Review of MCO Contract Year(s) 2013–2015
- A Member's Guide to Choosing a Medicaid Health Plan, 2016

- Kentucky Monthly Encounter Validation Report, February 2016
- EPSDT Encounter Data Validation 2015, October 2015
- Kentucky Medicaid Managed Care Early Periodic Screening, Diagnostic and Treatment Services (EPSDT) Review of 2014, Final June 2015
- Access and Availability PCP Survey, August 2015
- Access and Availability Dental Survey, February 2016
- FY16 Validation of Managed Care Provider Network Submissions: Audit Report, January 2016
- Web-Based Provider Directory Validation Study Summary Report Final, January 2016
- Kentucky Medically Fragile Children Focused Study, Final Report August 2015
- Assessment, Prevention and Treatment of Child and Adolescent Overweight and Obesity among the Kentucky Medicaid Managed Care Population, Clinical Focused Study 2015, Final Report September 2015
- Kentucky MCO Performance Improvement Project Progress Tracking Sheet, SFY 2016
- Quarterly Desk Audit Reports, 3rd Quarter 2015

A valuable component of this evaluation approach is the perspective gained from conference call interviews with key quality staff in DMS and in each of the five Kentucky MCOs. Dialog with MCO staff allowed the reviewer(s) to obtain insights and information not available in written reports and websites and to better understand the relationships between the MCOs, the state and the EQRO. Interviews were held with staff from DMS, Anthem BCBS Medicaid, Aetna Better Health of Kentucky, Humana-CareSource, Passport Health Plan, WellCare of Kentucky and IPRO, the EQRO.

Core Program Goals and Results

The primary goal of Kentucky's MMC Program is to improve the health status of Medicaid enrollees and to lower morbidity among enrollees with serious mental illness. As part of Kentucky's September 2012 Managed Care Quality Strategy, statewide health care outcomes and quality indicators for the goals and objectives were designated by DMS in collaboration with input from the Department of Public Health (DPH) and BHDID. Four major goal areas were determined as follows:

- Goal 1: Improve preventive care for adults
- Goal 2: Improve care for chronic illness
- Goal 3: Improve behavioral health care for adults and children
- Goal 4: Improve access to a medical home

To measure improvement and evaluate program success, benchmarks from the National Committee for Quality Assurance (NCQA) Quality Compass Medicaid[9] were included for each quality objective listed in the strategy. NCQA's Quality Compass Medicaid is derived from HEDIS data submitted to NCQA by Medicaid plans throughout the nation. Using these standardized measures as benchmarks allows states to make meaningful comparisons of their rates to rates for all reporting MMC plans nationwide and thus allows state policy makers to better identify program strengths and weaknesses and target areas most in need of improvement. In the Kentucky strategy, improvement is measured by a comparison of the state's rate to the 50th or 75th percentile of the 2012 national Medicaid benchmark or as an improvement of 10 percent of the difference between the state's baseline rate and the re-measurement rate. The use of national HEDIS performance is a reasonable approach to setting benchmarks particularly when the bar is set at a conservative 50th percentile rate for the majority of the measures, such as those regarding colorectal cancer screening, breast cancer screening, cervical cancer screening, cholesterol management, antidepressant medication management and outpatient visits. The 75th percentile benchmark was selected for measures of behavioral health care and access to care for adults and children.

In this evaluation summary report, results from Kentucky's HEDIS 2013 serve as baseline rates, and are compared to results from HEDIS 2015 for each measure in order to evaluate improvement from baseline to re-measurement. Kentucky's HEDIS 2013 and HEDIS 2015 state weighted average rates are shown in Tables 2, 3, 4, and 5 for the objectives listed in the Quality Strategy. Two methods were used to evaluate improvement.

First, the HEDIS 2015 weighted average rate for each objective was compared to the 2012 NCQA Quality Compass national Medicaid percentile rate for that measure, and a target rate was set to meet or exceed the selected Quality Compass percentile. For example, Kentucky's HEDIS 2015 weighted average statewide rate for the Breast Cancer Screening measure was 52.86% which was above the 2012 national Medicaid 50th percentile rate of 50.46%, thus exceeding the target rate for this measure.

Second, the level of improvement from baseline to re-measurement was calculated as a percent for comparison with a targeted percent improvement, i.e., 10%. None of the measures showed a 10% (or greater) improvement over the baseline. It should be noted that while a measure could reach the target rate using both methods, it is only necessary to meet or exceed one of the designated target rates for the objective to be met (Tables 2, 3, 4, and 5).[10] While the Quality Strategy includes the Colorectal Cancer Screening measure as an adult preventive care objective, this measure has not yet been specified for HEDIS Medicaid and thus no data were reported. Also included in the Quality Strategy, but not reported in HEDIS 2015, were two measures from the Comprehensive Diabetes Care (CDC) measure (CDC: LDL-C Screening, and CDC: LDL-C Control [< 100 mg/dL]) and two rates for the Cholesterol Management for Patients with Cardiovascular Conditions measure (CMC: LDL-C Screening and CMC: LDL-C Control [< 100 mg/dL]).

Table 2: Goal 1 – Improve Preventive Care for Adults

Objectives[1]	2012 Medicaid 50th Percentile	HEDIS 2013 Baseline Rate (%)	HEDIS 2015 Re-measure Rate (%)	Difference HEDIS 2013–2015	% Improved 2013–2015	Met Objective? (Yes/No)
HEDIS Colorectal Cancer Screening[2]	NR	NR	NR	N/A	N/A	N/A
HEDIS Breast Cancer Screening	50.46	51.67	52.86	1.19	2.30%	Yes
HEDIS Cervical Cancer Screening	69.10	49.61	46.95	-2.66	-5.36%	No

[1]Improvement in preventive care for adults is defined as "all measures meet/exceed 2012 Medicaid 50th percentile or improve by 10% of the difference of the baseline rate and the re-measurement rate."
[2]HEDIS rates for Colorectal Cancer Screening were not reported for Kentucky's Medicaid population.
[3]NR: not reported; N/A: not applicable.

Table 3: Goal 2 – Improve Preventive Care for Chronic Illness

Objectives[1]	2012 Medicaid 50th Percentile	HEDIS 2013 Baseline Rate (%)	HEDIS 2015 Re-measure Rate (%)	Difference HEDIS 2013–2015	% Improved 2013–2015	Met Objective? (Yes/No)
HEDIS Comprehensive Diabetes Care Measure						
Hemoglobin A1c Testing	82.38	83.38	88.78	5.40	6.48%	Yes
HbA1c Poor Control (> 9.0%)[2]	41.68	47.42	43.01	-4.41	-9.30%	No
HbA1c Control (< 8.0%)	48.72	44.51	48.22	3.71	8.34%	No
HbA1c Control (< 7.0%)	36.72	35	35.33	0.33	0.94%	No
Eye Exam Performed	52.88	41.91	41.61	-0.30	-0.72%	No
LDL-C Screening[3]	76.16	75.27	NR	N/A	N/A	N/A
LDL-C Control (< 100 mg/dL)	35.86	32.8	NR	N/A	N/A	N/A
Medical Attention for Nephropathy	78.71	76.67	82.31	5.64	7.36%	Yes
Blood Pressure Control (< 140/90 mmHg)	63.5	56.67	59.39	2.72	4.80%	No
HEDIS Cholesterol Management Measure						
LDL-C Screening[3]	82.48	79.91	NR	N/A	N/A	N/A
LDL-C Control (< 100 mg/dL)[3]	42.39	44.59	NR	N/A	N/A	N/A

[1]Improvement in preventive care for chronic illness is defined as "all measures meet/exceed 2012 Medicaid 50th percentile or improve by 10% of the difference of the baseline rate and the re-measurement rate."
[2]For this measure, a lower rate is better.
[3]This measure was retired for HEDIS 2015.
LDL-C: low-density lipoprotein cholesterol; NR: not reported; N/A: not applicable.

Table 4: Goal 3 – Improve Behavioral Health Care for Adults and Children

Objectives	2012 Medicaid 50th Percentile	HEDIS 2013 Baseline Rate (%)	HEDIS 2015 Re-measure Rate (%)	Difference HEDIS 2013–2015	% Improved 2013–2015	Met Objective? (Yes/No)
HEDIS Antidepressant Medication Management[1]						
Effective Acute Phase	49.42	58.36	58.28	-0.08	-0.14%	Yes
Effective Continuation Phase	32.42	42.98	43.95	0.97	2.26%	Yes
HEDIS Follow-up After Hospitalization for Mental Illness[2]						
Within 30 Days of Discharge	77.47	62.55	53.53	-9.02	-14.42%	No
Within 7 Days of Discharge	57.68	36.60	30.85	-5.75	-15.71%	No

[1]Improvement in behavioral health care for adults and children for these measures is defined as "measures meet/exceed 2012 Medicaid 50th percentile or improve by 10% of the difference of the baseline rate and the re-measurement rate."
[2]Improvement in behavioral health care for adults and children for these measures is defined as "measures meet/exceed 2012 Medicaid 75th percentile or improve by 10% of the difference of the baseline rate and the re-measurement rate."

Table 5: Goal 4 –Improve Access to a Medical Home

Objectives	2012 Medicaid 75th Percentile	HEDIS 2013 Baseline Rate (%)	HEDIS 2015 Re-measure Rate (%)	Difference HEDIS 2013–2015	% Improved 2013–2015	Met Objective? (Yes/No)
HEDIS Adult Access to Preventive/Ambulatory Health Services[1]						
Ages 20–44 Years	85.43	86.22	81.33	-4.89	-5.67%	No
Ages 45–64 Years	89.94	91.32	88.45	-2.87	-3.14%	No
Ages 65+ Years	91.11	91.31	84.24	-7.07	-7.74%	No
Total	86.67	88.75	83.99	-4.76	-5.36%	No
HEDIS Children and Adolescents Access to Primary Care[1]						
12–24 Months	97.88	97.65	97.49	-0.16	-0.16%	No
25 Months–6 Years	91.40	92.07	90.91	-1.16	-1.26%	No
7–11 Years	92.88	91.95	95.63	3.68	4.00%	Yes
12–19 Years	91.59	91.64	94.39	2.75	3.00%	Yes
Objectives	2012 Medicaid 50th Percentile (Visits/1,000 MM)[3]	HEDIS 2013 Baseline (Visits/1,000 MM)	HEDIS 2015 Re-measure (Visits/1,000 MM)	Difference HEDIS 2013–2015	% Change 2013–2015	Met Objective? (Yes/No)
HEDIS Outpatient and Emergency Department (ED) Visits for All Age Groups[2]						
Outpatient Visits	347.76	645.76	501.16	-144.60	-22.39%	Yes
ED Visits	N/A	84.45	83.92	-0.53	-0.63%	No

[1]Improvement in access to a medical home is defined as "all measures meet/exceed 2012 Medicaid 75th percentile or improve by 10% of the difference of the baseline rate and the re-measurement rate."
[2]Improvement in access to a medical home with regards to state aggregate HEDIS Ambulatory measures are defined as "outpatient visits meet/exceed 2012 Medicaid 50th percentile or improve by 10% of the difference of the baseline rate and the re-measurement rate" for the Outpatient Visits for all Age Groups measure, and as "emergency department (ED) visits decrease rate of utilization by 10% between the baseline rate and the re-measurement rate" for the ED Visits for all Age Groups measurement.
MM: member months; N/A: not applicable.

Eleven of Kentucky's HEDIS 2013 baseline rates met or exceeded the selected 2012 Medicaid national benchmark rates and, historically, 17 (60.7%) of Kentucky's re-measurement HEDIS 2014 rates met or exceeded the Medicaid national benchmark (see prior year Evaluation Summary Report). The latest HEDIS 2015 re-measurement results, however, did not compare favorably to the previous years, with only eight measures (38.1%) meeting or exceeding the selected 2012 national benchmark, while another 8 measures were within five percentage points of the national benchmark.

The eight measures that met objectives for the Quality Strategy included the following measures:

- Breast Cancer Screening
- CDC: Hemoglobin A1c Testing
- CDC: Medical Attention for Nephropathy
- Antidepressant Medication Management: Effective Acute Phase
- Antidepressant Medication Management: Effective Continuation Phase
- Children and Adolescents Access to Primary Care for ages 7–11 years and ages 12–19 years
- Outpatient Visits for all Age Groups

Opportunities for improvement are evident for the following measures with declining rates of performance from baseline to HEDIS 2015 re-measurement:

- Cervical Cancer Screening
- CDC: Eye Exam Performed
- Follow-up After Hospitalization for Mental Illness Within 30 Days of Discharge and Within 7 Days of Discharge
- Adult Access to Preventive/Ambulatory Health Services, all age groups
- Children and Adolescents Access to Primary Care, ages 12–24 months and ages 25 months to 6 years.

HEDIS 2015 measures for Follow-up After Hospitalization for Mental Illness Within 7 and 30 Days of Discharge were markedly below the HEDIS 2012 national benchmark by as much as 26.8 and 23.9 percentage points, respectively.

Using the updated CMS Quality Strategy Tool Kit for States,[11] the Managed Care Oversight – Quality Branch is currently rewriting the Quality Strategy and aim to have it completed by the end of 2016. Previous comprehensive evaluation summary reports have recommended that the state consider re-evaluating their benchmark targets and also expanding the goals to address the large enrollment of women and children in the MMC Program by including goals and objectives for prenatal/postpartum care and preventive measures for children, such as childhood obesity, dental care, counseling for nutrition and physical activity, and adolescent risk screening. Measures of member satisfaction should be considered. Additional measures related to kyhealthnow 2019 goals[12] would reflect the following objectives:

- Reduce Kentucky's rate of uninsured individuals to less than 5%
- Reduce Kentucky's smoking rate by 10%
- Reduce the rate of obesity among Kentuckians by 10%
- Reduce Kentucky cancer deaths by 10%
- Reduce cardiovascular deaths by 10%
- Reduce the percentage of children with untreated dental decay by 25% and increase adult dental visits by 10%
- Reduce deaths from drug overdose by 25% and reduce by 25% the average number of poor mental health days of Kentuckians

Unbridled Health, A Plan for Coordinated Chronic Disease Prevention and Health Promotion 2012–2016[13] is another approach that outlines quality indicators and strategies focusing on improving chronic disease outcomes in Kentucky. In December 2015, the Commonwealth submitted a state health system innovation plan (SHSIP) as part of the State Innovation Model (SIM) Design Grant.[14] Each of these documents incorporates a wealth of information on the health care system in Kentucky and goals for the future and should more than adequately serve as a basis for the state's updated Quality Strategy.

Quality Monitoring and Assessment

Kentucky's Strategy for Assessing and Improving the Quality of Managed Care Services outlines a strategy for quality oversight that is aligned with federal regulations. The Social Security Act (Part 1932(a))[15] requires states that contract with Medicaid MCOs to provide for an external independent review. The Balanced Budget Act of 1997 further described mechanisms states should use in monitoring Medicaid MCO quality. In early 2003, CMS issued a final rule defining the requirements for external quality review and state quality monitoring[16] and more recently a draft update of the final rule was released for comment.[17] This two-part section describes and assesses the activities of Kentucky's EQRO and the review and monitoring activities of DMS.

EQRO Activities Overview

States that provide care to Medicaid enrollees through MCOs are responsible for three mandatory external review activities and five optional activities listed in federal regulation. DMS has a contract with an EQRO to conduct all of the three mandatory review activities as well as many of the optional activities. The Kentucky EQRO work plan includes the following review activities:

- validate performance improvement projects (PIPs; mandatory),
- validate plan performance measures (PMs; mandatory),
- conduct review of MCO compliance with state and federal standards (mandatory),
- validate encounter data,
- validate provider network submissions,
- conduct focused studies,
- prepare an annual technical report,
- develop a quality dashboard tool,
- develop an annual health plan report card,
- conduct a comprehensive evaluation summary,
- develop PMs, and
- conduct access and availability surveys as needed.

In addition to the mandatory and optional activities listed in federal regulations, Kentucky also contracts with their EQRO to validate patient-level claims, conduct individual case reviews, pharmacy reviews, an annual EPSDT review and an annual progress report. Technical assistance and presentations are provided as needed.

Data Reporting Systems Review

Medicaid MCOs in Kentucky are required to maintain a management information system (MIS) to support all aspects of managed care operation including member enrollment, encounter data, provider network data, quality performance data, as well as claims and surveillance utilization reports to identify fraud and/or abuse by providers and members. MCOs verify, through edits and audits, the accuracy and timeliness of the information contained in their databases. They are expected to screen for data completeness, logic and consistency. The data must be consistent with procedure codes, diagnosis codes and other codes as defined by DMS, and in the case of HEDIS data, as defined by NCQA.

Of the data submitted to DMS, the EQRO is responsible for validating encounter data, provider network data and Healthy Kentuckians performance data based on validation protocols prepared by CMS.

Encounter Data

Encounters are defined as professional, face-to-face transactions between an enrollee and a health care provider. Submitted to DMS on at least a weekly basis, the encounter data system can be used to monitor service utilization, access, program integrity, and to develop quality performance indicators and calculate risk-based capitation rates.

In early 2013, the EQRO conducted a review of the state's encounter data systems and processes that are used to load MCO encounter files. This review covered state requirements for collection and submission; confirmation of the data submission format; description of the information flow from the MCO to the state; list of edit checks built into the state's system; process for voids and adjustments; error reports; state uses of loaded data; process for quality checks to

ensure that all data from the MCO's system and from vendors are loaded completely and accurately into the data warehouse; and key reasons for encounter record rejections. There was also a section on claims processing.

The EQRO receives a final extracted file from DMS each month and prepares a monthly data validation report for DMS summarizing each MCO's submission. The format of this report has two parts: a file validation report and an intake report. In both reports, data are presented for all MCOs and for each MCO separately. The most recent validation report reviewed for this evaluation was the Monthly Encounter Data Validation Report, for January 1, 2016 through January 31, 2016.

The intake report presents the number of encounters submitted to Kentucky Medicaid Management Information System (MMIS) and includes encounter volume reports by place of service. Between January 2015 and January 2016, the number of MMC encounters increased by 0.30% while enrollment increased by 3.12% (Table 6). The ratio of encounters per enrollee dropped from 7.89 in January 2015 to 7.68 in January 2016.

Table 6: Growth in Encounters 2015–2016

Events	January 2015	January 2016	Percent Change
Total Encounters	9,437,918	9,465,825	0.30%
Enrollment	1,195,439	1,232,789	3.12%
Encounters/enrollee	7.89	7.68	-2.90%

The validation report presents the number and percent of missing data and the number and percent of invalid data for each encounter variable. A separate validation table is created by encounter type including inpatient, outpatient, professional, home health, long-term care, dental care and pharmacy.

A review of missing data elements by place of service indicated a number of variables with a consistently high percent missing. Inpatient encounters are frequently missing procedure codes, performing provider key, procedure modifier codes, referring provider key and inpatient surgical International Classification of Diseases, Revision 9 (ICD-9) codes. Outpatient encounters are frequently missing diagnosis codes above diagnosis 3, performing provider key, procedure modifier, referring provider key and surgical ICD-9 codes. Professional encounters have a high percent of missing diagnosis codes above diagnosis 2, performing provider key, procedure modifier and referring provider key.

DMS continues to work with the MCOs, the EQRO and other branches of DMS to correct errors in encounter data submissions and to more closely align the edits used by MCOs with those used by DMS. Encounter Data Workgroup conference calls are held regularly for all plans together as well as one-on-one calls with each MCO. The MCOs actively attend the Encounter Data Workgroup conference calls and their participation on these calls has improved with MCOs suggesting agenda items and participating more in the discussions. DMS has made an effort to design conference call agendas that address issues identified by the MCOs and most importantly, have staff on the call who can answer specific questions or address specific issues on the agenda. Penalties and withholds are in place when an MCO is out of compliance. Once compliance is met, withholds, but not penalties, are released. DMS staff has invoked both penalties and withholds in an attempt to improve encounter data. DMS noted that the Managed Care Assignment Processing System (MCAPS, Kentucky's database for collecting provider panel information) is being phased out and thus no changes to rectify some of the missing data elements are planned. DMS staff is reviewing the edits required for submission to see if any other edits should be activated.

MCOs interviewed commented that their communication with DMS regarding encounter data submissions continues to be positive and the monthly conference calls with DMS continue to be helpful. The MCOs have increased staffing for encounter data monitoring and have developed internal structures, such as a cross-disciplinary encounter workgroup and an encounter monitoring dashboard for weekly analysis and validation. MCO technical expertise has been increasing, which has allowed each of the plans to better problem-solve issues prior to submission. All MCOs are actively focusing efforts on improving submission acceptance rates in order to avoid withholds/penalties for acceptance rates

below 95%. To further assist MCOs in tracking and improving their encounter data completeness, DMS should consider sharing the monthly EQRO encounter data validation reports with the MCOs.

EPSDT Encounter Data Validation 2015, Final Report, October 2015

This study was conducted to validate EPSDT-related visits and service codes by comparing medical record documentation to submitted encounter data for children enrolled in Kentucky MMC and to describe age-appropriate EPSDT services provided during the EPSDT visits. Medical record documentation of well-child visits identified by encounter data submission were reviewed for age-appropriate EPSDT screening components for a complete physical examination including a comprehensive health and developmental history; psycho-social and behavioral health assessment; dental assessment; developmental assessment; hearing and vision assessment; and health education including anticipatory guidance for child development, healthy lifestyles and accident and injury prevention. A sample of 120 enrollees for each of the five MCOs was randomly selected from the eligible population. Sixteen of the 552 records received were excluded for a final study sample of 536.

Study findings demonstrated that evaluation and management codes for comprehensive preventive visits reflected a well-child or preventive visit as indicated in medical record documentation in nearly all (99.6%) cases. Immunization status was documented in over 87% of preschool children, for whom many immunizations are required, but only 63% of adolescents had immunization status documented. Physical examination components continued to be well documented. Between 2013 and 2014, improvement was evidenced in the rates of oral health assessment, developmental screening, mental health assessments and adolescent substance use screening. Over 90% of records that indicated a developmental concern also included documentation of follow-up actions.

Opportunities for improvement were identified in rates of prevention and identification of overweight and obesity, vision and hearing screening, adolescent depression screening and oral health screening for adolescents. More than one third (35%) of the study sample, and 44% of adolescents, had neither assessment of oral health needs during their EPSDT visit nor referral for dental care. These study findings should be examined in more detail in future studies in order to support Kentucky's ongoing focus on oral health care in the Healthy Smiles Kentucky Program and the kyhealthnow 2019 goal to reduce the percentage of children with untreated dental decay by 25%. MCOs were encouraged to continue to focus on persistent opportunities for improvement in receipt of EPSDT services identified in this study and to access CMS and other resources, such as the National Academy for State Health Policy's "EPSDT Resources to Improve Medicaid for Children and Adolescents."[18]

Provider Network Data

MCO provider networks must include a sufficient number of providers and provider types to deliver contracted services to their target Medicaid populations and meet state accessibility standards. DMS requires the EQRO to verify the provider information submitted by Kentucky MCOs to MCAPS. MCOs must submit provider data monthly for all plan-enrolled providers electronically to Kentucky's secure MCAPS. Kentucky uses MCAPS data to evaluate the adequacy of the MCOs' networks, assess capacity, create performance measures related to the MCOs' provider networks, and conduct access and availability studies; hence, the accuracy of the source data is essential. In January 2016, the EQRO completed two audits of Kentucky's provider network submissions: one audit to validate provider network submissions and a second one to validate web-based provider directories.

Validation of Managed Care Provider Network Submissions, Audit Report, January 2016

This provider network validation used a sample of providers randomly selected from MCAPS. A two-phase mailing was conducted to validate the accuracy of the provider directory data submissions for primary care providers (PCPs) and specialists participating with any of the five MMC MCOs: Aetna Better Health of Kentucky, Anthem BCBS Medicaid, Humana-CareSource, Passport Health Plan and WellCare of Kentucky. Surveys were sent to 100 PCPs and 100 specialists from each MCO. The overall response rate was 58.1%. Returned responses validated information that was correct in the MCAPS data system and reported revisions that should be made to incorrect data. A total of 206 (45.2%) providers who returned the survey noted at least one revision. Four survey items had a substantial percentage of providers with missing data in the provider directory file: provider license number, secondary specialty, Spanish and other languages spoken. There was an average of 1.83 revisions per provider for the 206 providers who submitted surveys with changes. A comparison of the statewide rates of accuracy, between the last audit conducted in April 2015 and this more recent audit, revealed an improvement from 49.1% to 54.8%, although the difference was not statistically significant.

Plan-specific reports including a list of changes and a list of incorrect addresses were sent to the MCOs and requested that the MCOs update their provider directory file with this information. Based on the findings from the provider network validation studies, the EQRO also recommended that DMS consider expanding the MCAPS data dictionary to include more specificity in the definitions of the data elements and that they consider adding several data elements to MCAPS to collect information about wheelchair access, hours at site, interpreter services/translation services available, provider usage of health information technology (HIT) and providers' Patient-Centered Medical Home Certification status and level. Other recommendations called for clarifications or relocation for the field "Spanish" and secondary specialty. The reviewer suggested that DMS may want to contact MMC programs of other states to learn how other states have augmented their data collection of provider network information.

Web-Based Provider Directory Validation

The web-based provider directory validation was performed to ensure that enrollees are receiving accurate information regarding providers when they access the plan's web-based directory. The objectives of this study were two-fold: 1) to determine if all providers included in the MCAPS submission for each MCO were listed in the web-based provider directory, and 2) to ensure that provider information published in the MCOs' web directories is consistent with the information reported in the MCAPS and/or the provider network audit responses. The January 2016 study used provider network data submitted in September 2015 to the EQRO for the five MCOs: Aetna Better Health of Kentucky, Anthem BCBS Medicaid, Humana-CareSource, Passport Health Plan and WellCare of Kentucky. A random sample of 50% of providers who responded to the provider network validation study was drawn, but no more than 50 providers from each MCO (25 PCPs and 25 specialists) were audited. For each survey that was included in the web validation sample, the reported provider information was validated against the corresponding MCO's web directory within one week of receiving the survey response.

Results of the survey indicated that 97% of the PCPs and 77% of the specialists were found in the MCO web directories. Overall accuracy was measured as the percentage of providers in the web validation sample that had accurate provider network information when checked against the web-based directory. The resulting overall accuracy rate of the provider information published in the web directories was 80% for PCPs and 88% for specialists.

It was suggested that DMS follow up with MCOs to ensure that inaccuracies in provider information from this validation study and the provider network survey are corrected and are accurately reflected in both the MCO's MCAPS submissions and their web directories.

Quality Performance Data

Quality performance data are the basis for quality review and improvement activities. MCOs are responsible for contracting with a certified HEDIS auditor to conduct an NCQA-approved audit prior to submitting their HEDIS and CAHPS[19] data to DMS. The Healthy Kentuckians data, submitted annually to DMS, are validated by the EQRO based on the CMS protocol, "Validating Performance Measures: A Protocol for Use in Conducting Medicaid External Quality Review Activities (updated 2012)."[20] All audit findings are compiled as part of the EQRO's validation of quality performance data, and audit reports including reportable rates are prepared for each MCO. The performance validation methodology includes an information systems capabilities assessment; denominator validation; data collection validation; and numerator validation. For HEDIS 2015, all effectiveness of care, access and availability, dental access and utilization measures were required to be submitted. DMS elected not to rotate any of the measures that were selected for rotation by the NCQA.

Quality performance data results were presented in the following EQRO documents:[21]

- A Member's Guide to Choosing a Medicaid Health Plan, 2016 (a.k.a. the Annual Health Plan Report Card);
- Kentucky MCO Dashboard HEDIS 2015 (for internal DMS use only); and
- the 2015 External Quality Review Technical Report.

Annual Health Plan Report Card

An annual health plan report card is developed by the EQRO in collaboration with DMS to provide quality performance information as a guide for individuals when choosing a MMC health plan. Entitled "A Member's Guide to Choosing a Medicaid Health Plan," the 2015 edition is available in a printed version and electronically on the DMS website.[22]

The format for 2016 is a tri-fold brochure with an MCO comparison of performance in the center and MCO contact information and questions members should ask their MCO on the back. This tool is a consumer-friendly document that allows an enrollee to compare each MCO's performance in the areas of preventive care, access and satisfaction by the number of stars shown, i.e., 5 stars representing excellent, 4 stars for above average, 3 stars for average, 2 stars for below average and 1 star for much below average performance. Public presentation of MCO quality data is being used by many state MMC programs to encourage MCO quality improvement. With each new version, DMS, in collaboration with the EQRO, has revised the content and format of the report. Input from the MCOs has also been helpful. Going forward, DMS may want to research various other options for content and format to determine what their members would prefer. Conducting member focus groups is one way to obtain their input and perspectives. Researching what other states present in an annual report should also be pursued.

Quality Performance Dashboards

Two types of MCO dashboards are used for monitoring. A monthly MCO dashboard is prepared by DMS using data obtained from MCO monthly reports submitted to DMS. This dashboard presents information regarding claims, encounter data submissions, prior authorizations, as well as information about member, provider and behavioral call-center calls. Financial metrics, provider credentialing, terminations from MCO, program lock-ins and the number of new members in the foster care and adult guardianship programs are also included. Data cells that are in contract compliance are highlighted in green while cells shaded red indicate lack of compliance.

Using HEDIS 2015 data, the EQRO designed a dashboard to pictorially describe national, statewide and MCO-specific performance on selected quality and satisfaction measures using graphs and charts. This version of a dashboard is posted on the EQRO website for DMS internal monitoring purposes only. The dashboard's content is comprehensive and clearly displayed. It is easy to navigate the site and quickly obtain information, making it a more useful tool for consumers/enrollees rather than for internal monitoring.

Technical Report

The Balanced Budget Act of 1997 requires state agencies that contract with Medicaid MCOs to prepare an annual external, independent review of quality outcomes, timeliness and access to health care services. A draft version of the 2016 External Quality Review Technical Report, completed in April 2016 for the MCO contract years 2013–2015 includes results for all five Kentucky Medicaid MCOs: Aetna Better Health of Kentucky (formerly CoventryCares of Kentucky), Anthem BCBS Medicaid, Humana-CareSource, Passport Health Plan and WellCare of Kentucky. The report provides quality performance data, CAHPS satisfaction data, results of compliance reviews, validation results of Kentucky performance measures and validation of PIPs. MCO strengths and opportunities for improvement are also outlined for each MCO. The MCOs are required to submit a response for each opportunity for improvement, which are then published in the next annual technical report. While the federal regulations require an annual review of access, timeliness and quality of care, a full review is only necessary every three years.

Annual Compliance Reviews

Federal regulations require that every state with an MMC program conduct a full review of MCO compliance with state and federal regulations at least once every three years. The reviews can be done by the state or the EQRO. In Kentucky, the EQRO conducts the annual reviews for compliance with contract requirements and state and federal regulatory standards. In reporting year (RY) 2015, four MCOs (CoventryCares of Kentucky [now Aetna Better Health of Kentucky], Humana-CareSource, Passport Health Plan and WellCare of Kentucky) underwent a partial review, based on findings of the previous review. Anthem BCBS Medicaid received a full review since 2014 was its first year participating in the Kentucky Medicaid Program.

According to 42 CFR§ 438.360, states can use information obtained from a national accrediting organization's review for the mandatory external quality review activities conducted by either the state or its EQRO. With this authority, states can deem NCQA standards equivalent to state requirements and thus use the information obtained through

accreditation surveys to streamline their oversight process.[23] Since Kentucky has specific measures that are not included in the accreditation reviews, the state prefers to use a policy for deeming based on previous plan performance rather than deeming based on accreditation.

DMS remains committed to conducting compliance reviews on an annual basis. In 2016, the compliance reviews were conducted in January instead of March for an earlier turnaround time in order to complete the technical report on schedule. Also, over the past two years, all MCOs have been reviewed during the same one week period. DMS tracks the non-compliant and minimal scores for multiple years and issues withholds/penalties for issues remaining in this status for two or more years. They are also tracking substantial findings over multiple years to identify whether the same reasons are resulting in less than full compliance and if so, instead of another substantial finding, the finding will be scored minimal until it is fixed.

In an effort to streamline the compliance review requirements, beginning in 2014, the EQRO received selected MCO quarterly reports as they were submitted and created desk audit tables by plan and by quarter for the following review areas:

- Availability and Access (Reports 12A and 13)
- Continuity and Coordination (Reports 79, 65, 66 and 20)
- Coverage and Authorization of Services (Report 59)
- Enrollee Rights (Report 11)
- Grievance System (Reports 27, 28 and 29)

DMS commented that reviewing the quarterly reports as they are submitted has made the annual compliance review easier as some of the documents have already been reviewed and acted upon by the MCOs. At the annual review, the EQRO only has to recheck elements found non-compliant in the quarterly reviews. DMS has been training the MCOs to use this tool throughout the year to bring non-compliant elements into compliance prior to the annual review. DMS continues to work with the EQRO to further improve the process.

MCOs commented that they appreciate these summaries and find the comments from the EQRO helpful, particularly on the narrative reports. Having the EQRO's findings during the year does allow the MCO to address issues during the year rather than during or after the compliance review is completed. The timeliness of these audits was mentioned as an issue, especially in light of this year's schedule for conducting the compliance reviews in January, rather than March. Only reports through the second quarter of 2015 were completed prior to the review. MCOs further commented that the process of summarizing the selected quarterly report information across plans highlighted the variability in the data reported and raises questions about how each of the MCOs are interpreting the questions. It was generally agreed that more data specification and interpretive guidance is needed so that all MCOs are reporting consistently and that a fair comparison can be made across plans.

Changing the month in which the compliance reviews were conducted also presented problems for some of the MCOs. With end-of-year activities requiring attention, MCOs were challenged to find enough time and staff available to pull together the supporting documentation and medical records for the review. Receiving more advance notice regarding necessary supporting documentation and medical record lists would give the MCOs more time to prepare. Conducting the reviews during the same week, for all five MCOs, also means that each MCO may have different reviewers this year than in previous years. MCOs commented that this can be problematic as the reviewers may not be as familiar with the plan and/or the managed care contract and thus time has to be spent providing background information to better inform the reviewers. The EQRO should try to have at least one consistent reviewer from year to year for each MCO, preferably the lead reviewer.

State Review Activities Overview

As described earlier, the Kentucky MMC quality review and oversight activities are the responsibility of DPQ&O composed of three branches:

- Managed Care Oversight – Contract Management Branch has oversight responsibility for MCO contract compliance including review and analysis of monthly encounter data reports from the EQRO and review of quarterly reports submitted directly to DMS from the MCOs. They actively initiate penalties/withholds for MCO non-compliance.
- Disease and Case Management Branch has oversight responsibility for Medicaid enrollee care coordination including resolving provider issues identified in grievances and appeals and disenrollment for cause.
- Managed Care Oversight – Quality Branch oversees the EQRO contract and works with the EQRO to develop quality measurement and improvement initiatives.

State review activities are described on the DMS website where consumers can also access many quality-related materials including DMS branch responsibilities, MCO contact information, HEDIS and CAHPS results and all EQRO reports. Public posting of the quality review reports is a critical part of the state's effort to provide data transparency regarding its MMC program. It also acts as an incentive for MCOs to improve performance when each MCO's data are compared to the data of other MCOs, and to state and national benchmarks.

MCO Reporting Requirements

The state's current Medicaid MCO Model Contract incorporates established standards for access to care, structure and operations and quality measurement and improvement. To monitor MCOs' compliance with these standards, Appendix K of the model contract includes a list of monitoring reports MCOs are required to submit on a monthly, quarterly and annual basis. All three branches have staff reviewing specific reports to assure that they are all adequately reviewed and information is tracked and evaluated. The Managed Care Oversight – Quality Branch prepares a monthly MCO dashboard summary of data from several key monthly reports.

Originally created in September 2011, Appendix K contained 152 required reports and 11 exhibits with crosswalks, definitions and codes. While monitoring MCO compliance in the early phases of Kentucky's MMC Program was critical, the reporting burden on MCOs and the report review burden on DMS continued to grow as program enrollment increased along with the number of MCOs. In response, the Managed Care Oversight – Quality Branch initiated a workgroup that included members from DMS, DBHDID and the MCOs to review all required MCO reports. DMS requested MCO input and meetings were held to discuss ways to modify, combine, reduce or eliminate some of the required reports in order to reduce the burden and to assure that all MCOs were reporting data in the same way to allow for valid plan-to-plan comparisons. As a result, a revised Appendix K was drafted and lists 68 (or 45%) of the originally listed reports as "inactive." The behavioral health reports were modified to get the data that DBHDID needed in a correct and consistent format. Some reports have been changed from monthly to quarterly and some reports were revised to provide better and more accurate data. DMS has also been working with the EQRO to revise and clarify the reports used in the quarterly desk audits.

One common theme in the MCOs' comments regarding the reporting requirements was that they do not receive feedback from DMS. Feedback would help clarify and improve their responses. Providing interpretive guidance for each report and more data specification, including data sources to be used, would help improve the consistency in MCO reporting. The MCOs agreed that the reporting requirement changes were helpful and appreciated the opportunity to provide input and suggestions to DMS in the process. They all further agree, however, that more needs to be done and that the meetings to discuss the reports should continue as a work-in-progress. Several MCOs interviewed gave specific suggestions of reports that could be changed, combined or eliminated. One MCO also commented that since changes in the reporting requirements are made throughout the year, it would be helpful when DMS distributes a revised Appendix K that they include a list of specific report changes and include any new report templates that the MCOs will be required to use going forward.

Monitoring Access to Care

MCOs are required to meet contract standards for access to providers geographically by county and by average distance (in miles) to a choice of providers for all members. MCOs monitor compliance with these network standards through geo-access analysis of providers, including PCPs, primary care centers, dental care providers, specialty care providers,

non-physician providers, hospitals, urgent care centers, local health departments, federally qualified health centers, pharmacies, significant traditional providers, maternity care providers, vision care providers and family planning clinics. MCOs also monitor access to high-volume specialists, such as those specializing in cardiology, obstetrics/gynecology and surgery. Analyses are provided for enrollees in urban and rural areas. The EQRO's Quarterly Desk Audit of Availability and Access of Services for the compliance reviews identified gaps in access that could be addressed by the MCO prior to the annual review. The EQRO commented that the MCO geo-access reports were inconsistent in content; for example, some reports did not cover access to all required provider types and some provider types were not submitted by urban/rural region.

Each MCO regularly conducts surveys to determine appointment availability for urgent or non-urgent care in accordance with contract availability standards. Because these surveys use various methods for data gathering, it is difficult to summarize and aggregate results on a state-program level. DMS reports that the Managed Care Oversight – Contract Compliance Branch conducts secret shopper calls monthly to random providers in the MCOs' networks to assess compliance with the contract standards.

Access and Availability PCP Survey

During 2015, DMS and the EQRO collaborated on a design to conduct an access and availability survey for PCPs using the "secret shopper" methodology. Primary care providers included PCPs, pediatricians and obstetricians/gynecologists (ob/gyns). The objective of the survey was to measure compliance with the contract standard stating that routine services must be provided within 30 days and non-urgent care must be provided within 48 hours. Providers must also be accessible to member phone calls 24 hours a day, 7 days a week. MCOs participating in the Kentucky MMC Program must maintain a compliance rate of at least 80% to satisfy applicable appointment standards. All five MCOs participated in the survey: Anthem BCBS Medicaid, CoventryCares of Kentucky (now Aetna Better Health of Kentucky), Humana-CareSource, Passport Health Plan and WellCare of Kentucky.

From provider network data electronically submitted by each of the MCOs, a random sample of 250 providers per MCO was selected for a total of 1,250 providers. The methodology used several different scenarios for requesting an appointment for routine care, non-urgent care or after-hours care. Surveyors made up to four attempts to contact a live person at each provider office to complete the survey.

Among the 525 providers called for a routine visit, 453 (86.3%) were able to be contacted and among the 525 called for a non-urgent visit, 459 (87.4%) were contacted. Overall compliance rates were 31.8% for routine calls, 24.8% for non-urgent calls and 52.0% for after-hours calls, all substantially below the standard of 80%. For routine calls, compliance rates were highest for ob/gyns, while for non-urgent and after-hours calls, compliance rates were highest for pediatricians. In contrast, PCPs had the lowest compliance rates for routine calls and ob/gyns had the lowest compliance rates for non-urgent and after-hours calls.

Access and Availability Dental Survey

A survey of dental providers was completed in February 2016. A total of 1,100 dentists were randomly selected from provider network data files submitted by the five participating MCOS: Aetna Better Health of Kentucky, Anthem BCBS Medicaid, Humana-CareSource, Passport Health Plan and WellCare of Kentucky. A "secret shopper" methodology was used to test provider compliance for two types of appointments: routine appointments (within 21 days) and urgent appointments (within 48 hours).

Overall, 92.4% of the dentists who were called for routine appointments were able to be contacted and 88.2% of the dentists called for an urgent appointment were able to be contacted. Routine appointments were made with 59.4% of the dentists contacted and urgent appointments were made with 62.5% of those contacted. After allowable exclusions, only 35.2% of the dentists called for a routine appointment were able to be contacted and an appointment made within the timeliness standards of the contract. For urgent appointments, only 31.6% of the dentists were compliant. For both routine and urgent calls, the most common reasons for not making an appointment included: the provider was not in the plan; the provider practice was restricted to specialty care; the provider was not accepting new patients; the provider was not at the site and no alternative provider was available; and the staff was not scheduling any appointments at this time.

DMS expressed concern over the results of both of these surveys and began an in-depth root cause analysis (RCA). They are following up on the call disposition summary reports from the EQRO and conducting on-site audits with the MCOs. They are also surveying a random sample of providers that the EQRO could not get an appointment with to see if these providers are still accepting new patients and/or are still participating with the MCOs. Standing agenda items for network adequacy and access/availability have been added to all operations meetings for continued discussion. CAPs will be issued when compliance problems are identified.

For both access and availability surveys, each MCO received a listing of providers in their plan who could not be contacted, who could not make an appointment, and those who offered an appointment that was not within the correct time frame. MCOs were given 30 days to review the files and submit explanations regarding the contacts and appointments that could not be made. Each MCO followed up with their providers to gain information regarding the practice and to re-educate the provider (and the office manager) on contract requirements including standards for providing access. MCOs also resurveyed these providers and reported improved results. The EQRO will prepare a summary report categorizing the MCO responses. MCOs were also instructed to update their provider systems to ensure that these providers are correctly reported in their provider network files.

MCOs interviewed agreed that there is an access/availability issue for PCPs and dentists in Kentucky MMC, but felt that the results of this survey did not accurately reflect the true rate of access. Several methodological issues raised by the MCOs regarding the survey included:

- The small sample size may not have been large enough to represent the network for the MCOs with larger enrollment.
- A process should be added to allow a call-back number to be provided for practices using an electronic voice messaging system.
- Calls should not be failed when the caller is referred to another provider.
- The definition of urgency should be better clarified in the scenarios.

Care Coordination

With the implementation of the ACA, case management has become increasingly important in improving the quality and efficiency of health care. MCOs have traditionally embraced this concept and many have developed sophisticated systems to identify enrollees at risk, provide disease and case management services and monitor and track outcomes. As of September 2015, less than 1% of Kentucky's MMC enrollees were enrolled in case management and another 8.26% were enrolled in disease management (Table 7).

Table 7: Enrollment in Case and Disease Management, July–September 2015

Members	Enrolled at End of Period	% of Members
Total members	1,193,510	-
Enrolled in case management	5,141	0.43%
Enrolled in disease management	98,578	8.26%

To identify new enrollees with care coordination needs, MCOs are required to request that all members complete an initial health risk assessment (HRA). MCOs also identify enrollees in need of care coordination by using encounter data algorithms or predictive modeling to track high-risk diagnosis codes, high utilization, repeat use of emergency rooms, frequent inpatient stays and hospital readmissions as markers. DMS's Disease and Case Management Branch plays an active role in working with MCOs to enhance care coordination and case management referrals for special populations, such as medically fragile children, foster children and adults in guardianship. The disenrollment for cause data help DMS identify member problems with their MCOs, to analyze trends and to refer members directly to case management.

Compliance reviews conducted in 2015 and in 2016 continue to note coordination challenges between the MCOs and Kentucky's DCBS and DAIL agencies. It is critical that the MCOs have access to baseline information about individuals identified by DCBS and DAIL to enable timely and appropriate referrals and for MCO case managers to assure access to needed services. DMS reported that the MCOs continue to have monthly meetings with DCBS and DMS to address

service plans. They are working collaboratively to ensure the care coordination of these members. DMS and the EQRO conducted a care coordination case study on one of the MCOs and shared findings from the study with all Kentucky Medicaid MCOs to improve care coordination in these medically fragile populations. In addition, DMS and the EQRO conducted a focused study to evaluate health care utilization and coordination of care among medically fragile children. Results from this study were shared at a CMS conference in Washington D.C.[24]

Several Kentucky MCOs have found that an aggressive, proactive approach has helped them to better coordinate case information with DCBS. One MCO developed a tracking mechanism to identify service plans requested, received and those still pending. Another MCO established an electronic portal between the MCO and DCBS to share service plans and case records. In addition to conference calls, some MCOs are scheduling monthly, face-to-face meetings with DCBS, at DCBS offices. An all-plan meeting with DCBS was held in May 2016 to discuss improved communication through workshops and training.

EPSDT Compliance

EPSDT is a federally required Medicaid program for children that has two major components: EPSDT screenings and EPSDT special services. The Screening Program provides well-child check-ups and screening tests for Medicaid eligible children in specified age groups. EPSDT special services are only provided when medically necessary, if they are not covered in another Medicaid program, or are medically indicated and needed in excess of a program limit. DMS contracts with Kentucky's EQRO to validate that the MCOs' administration of EPSDT benefits is consistent with federal and state requirements.

Data submitted on form CMS-416[25] indicated an increase in the number of individuals eligible for EPSDT between RY 2014 and RY 2015 but a slight decline in the screening rate during this period from 83% in RY 2014 to 82% in RY 2015 (Table 8). Total eligible members receiving at least one initial or periodic screen (referred to as the participation rate) increased slightly from 57% in RY 2014 to 58% in RY 2015. CMS has historically set a goal of 80% for EPSDT screening and participation. National EPSDT rates, as of June 16, 2015, with four states not reporting, were 86% for screening and 61% for participation in 2014. Kentucky's reported screening and participation rates were thus slightly lower than the national average rates in 2014.

Table 8: EPSDT Screening and Participation Rates – RY 2014 and 2015

Indicator[1]	RY 2014	RY 2015
Total individuals eligible for EPSDT	576,542	591,453
Screening rate	83%	82%
Participation rate	57%	58%

[1]Rates were reported by Kentucky MCOs on Form CMS-416 for the reporting year (RY) from October 1, 2013 through September 30, 2014 (RY 2014) and from October 1, 2014 through September 30, 2015 (RY 2015).
EPSDT: Early Periodic Screening, Diagnostic and Treatment

Kentucky Medicaid Managed Care Early Periodic Screening, Diagnostic and Treatment Services (EPSDT) Review of 2014, Final June 2015

The purpose of this report was to validate whether the MCOs' administration of EPSDT benefits was consistent with federal and state requirements and expectations. All five Kentucky Medicaid MCOs were evaluated, including Anthem BCBS Medicaid, CoventryCares of Kentucky (now Aetna Better Health of Kentucky), Humana-CareSource, Passport Health Plan and WellCare of Kentucky. Data for Anthem BCBS Medicaid were limited since the MCO had just begun enrollment in 2014.

Data sources for this study included:

- 2015 Annual Compliance Review findings,
- 2013 EPSDT Encounter Data Validation Study,
- HEDIS 2014 and Healthy Kentuckians performance measure rates,
- Kentucky statutory reports relevant to EPSDT services, including the following:
  - Quarterly Report #24 – Overview of Activities Related to EPSDT, Pregnant Women, Maternal and Infant Death,

- Annual Report #93 – EPSDT Annual Participation Report (as reported on CMS-416),
- Quarterly Report #17 – Quality Assessment and Performance Improvement Work Plan,
- Quarterly Report #85 – Quality Improvement Program Evaluation,
- Annual Report #94 – CAHPS Medicaid Child Survey,
- Annual Report #86 – Annual Outreach Plan,
- Quarterly Report #18 – Monitoring Indicators, Benchmarks and Outcomes, and
- Quarterly Report #19 – Performance Improvement Projects.

The 2015 Annual Compliance Review revealed that all five MCOs were fully or substantially compliant with most review elements related to EPSDT services. Expected EPSDT screenings among eligible children and adolescents were below 80% for four of the five MCOs, with the exception of Passport Health Plan. All five MCOs had participation rates for EPSDT services considerably below the 80% benchmark goal. Older age groups had especially low participation rates for all MCOs. Reported HEDIS 2014 measures further revealed opportunity for improvement in the percentage of children who received expected well-child visits, which would be equivalent to EPSDT screening visits.

All five MCOs showed evidence of providing a sufficient network of EPSDT providers and they all implemented numerous initiatives to educate and outreach to physicians and members to help facilitate EPSDT services. Some innovative member outreach, such as promoting EPSDT services at schools, meetings of grandparents raising grandchildren and homeless advocacy groups, are promising practices that should be monitored for effectiveness. All MCOs engage providers in outreaching to members in need of services and all actively track receipt of services, but with participation rates far below the 80% goal, the effectiveness of some of these approaches needs to be further studied. Case management outreach and service coordination for members needing services was documented by all MCOs, with the exception of DCBS clients.

The report noted that efforts to monitor providers' delivery of EPSDT services had improved from the previous year, but results of the EPSDT validation study and HEDIS and Kentucky performance measures revealed opportunities for improvement in mental health, vision, hearing, and developmental screening; depression and behavioral risk screening for adolescents; body mass index (BMI) screening and nutrition/physical activity counseling; immunizations and lead screening. Oral health assessment was also found lacking in the validation study.

As a limitation, it was noted that the MCOs' statutory reports did not appear to follow a standardized format, thus resulting in variation in the report contents which made MCO comparisons difficult to interpret.

State-MCO-EQRO Communication

Communication and collaboration are important in promoting effective quality monitoring and improvement. On a regular basis and sometimes ad hoc, communication between the state, MCOs and the EQRO has developed over time in a variety of ways. DMS has made considerable effort to improve communications as evidenced by the following:

- regular quarterly meetings with MCO quality directors; operations staff; EPSDT coordinators; behavioral health staff and information technology (IT) staff;
- monthly encounter data meetings;
- continuing meetings to discuss MCO reporting requirements;
- MCO medical directors' meetings led by DMS's medical director;
- Coordination and facilitation of numerous meetings and workgroups by the Disease and Case Management Branch, including MCOs and DBHDID, DCBS and DAIL;
- EQRO-initiated periodic conference calls with all MCOs and with each MCO to discuss PIP progress and problems;
- technical assistance provided by the EQRO and DMS to MCOs both by phone and in scheduled training sessions; and
- DMS website postings, which include reports and data generated by all three branches of the Division of Program Quality and Outcomes and the EQRO.

All MCOs reported good working relationships between the state, MCOs and the EQRO. Input and feedback from the MCOs is often sought and both DMS and the EQRO are responsive to phone calls and questions. MCOs commented that there was not a lot of communication around the quarterly reports. In terms of the meetings, it was mentioned that

most meetings had written agendas, but meeting notes were not always prepared and distributed, especially for the encounter data meetings. Several MCOs also commented on the value of face-to-face meetings over conference calls.

During interviews with the MCOs, a number of suggestions to improve communication and collaboration were discussed:

- prepare and distribute meeting notes for all meetings;
- continue to meet to discuss reporting requirements, report formats and data specifications; and
- have more face-to-face meetings and meetings with more clinical interaction.

Strategies and Interventions to Promote Quality Improvement

Kentucky's Quality Strategy includes several activities focused on quality improvement including PIPs and focused clinical studies. While not in the Quality Strategy, DMS has further enhanced their quality improvement activities through public reporting and financial incentives. This section discusses the current projects completed or ongoing by the MCOs, DMS and the EQRO.

A review of other states' quality strategies further provides an opportunity to examine a range of different approaches to monitoring MMC quality and conducting quality improvement. Experience from other states and innovative improvement initiatives are presented for consideration in Attachment A for New York State,[26] California,[27] Florida,[28] Maryland[29] and New Jersey.[30]

Performance Improvement Projects

A protocol for conducting PIPs was developed by CMS to assist MCOs in PIP design and implementation. Federal regulations require that all PIPs be validated according to guidelines specified by CMS. In Kentucky, the EQRO is responsible for validating all PIPs.

The PIP protocol is based on a problem solving approach to achieve improvement known as a Plan-Do-Study-Act (PDSA) cycle.[31] Each state's MMC program determines the number of PIPs required to be conducted each year. In Kentucky, two new PIP topics are proposed each year and are generally completed in two to three years. Each MCO is likely to have two to six PIPs at various stages of activity: initiation, baseline measurement, implementation, and up to two years of re-measurement (Table 9). Initially, Kentucky MCOs selected their own PIP topics, usually based on HEDIS results that needed improvement. More recently, DMS has designated two topic categories: physical health and behavioral health.

The EQRO's process for validating MCO PIPs starts with DMS approval of the PIP topic. Then, using a team of two to three reviewers, the EQRO reviews the PIP proposal, topic selection rationale, methodology, planned interventions and study indicators. The EQRO follows each PIP through to completion with conference calls with each MCO to discuss progress and problems. In addition, the EQRO also conducts training for MCOs on PIP development and implementation. PIP results are scored based on the first and second re-measurement results. While a PIP's result may or may not indicate that an MCO achieved success in meeting their goals, every PIP can provide a valuable learning experience in the QI process which can be applied to other improvement efforts.

Statewide Collaborative PIPs

In 2014, Kentucky initiated its first statewide collaborative PIP, entitled "Safe and Judicious Antipsychotic Medication Use in Children and Adolescents," to satisfy the behavioral health category requirement. In 2015, the statewide topic selected was "The Effectiveness of Coordinated Care Management on Physical Health Risk Screenings in the Seriously Mentally Ill Population." MCOs are required to actively participate in the collaborative PIP efforts and attend all scheduled conference calls including all-plan calls and individual plan calls. DMS commented that the MCOs are very active in trying to make their PIPs successful and collect solid results. The EQRO outlined key strengths of the first statewide PIP which included strong rationale supported by references; thorough barrier analyses; and robust interventions that address members, providers and health plan processes. Of specific note, Aetna Better Health of Kentucky developed a "Pediatric Antipsychotic Look-up Tool" that has the potential to inform targeted provider and member interventions and Passport Health Plan is conducting a pilot program to address access to psychiatric services in rural areas via tele-health and placing behavioral health practitioners in rural primary care settings.

Areas identified for improvement were data collection and measure reporting, alignment of interventions with performance measures, and correction of the study timeline. Anthem BCBS Medicaid faced enrollment limitations for the child and adolescent age groups resulting in eligible population size less than 30 members. Aetna Better Health of Kentucky experienced a late start after several revisions in the study design and needed to develop alternate strategies and/or work-arounds to address the reported delays due to the transition of CoventryCares of Kentucky systems and processes to Aetna Better Health of Kentucky systems.

Table 9: PIP Project Status 2013–2016

Plan	PIP Topic	Proposal Submitted	PIP Period
All-plans	Safe and Judicious Antipsychotic Medication Use in Children and Adolescents	2014	2015–2017
	The Effectiveness of Coordinated Care Management on Physical Health Risk Screenings in the Seriously Mentally Ill Population	2015	2016–2018
Anthem BCBS Medicaid	Reducing Avoidable Emergency Department Utilization	2014	2015–2017
	Increasing Annual Dental Visits	2015	2016–2018
Aetna Better Health of Kentucky (CoventryCares of Kentucky)	Major Depression: Anti-Depressant Medication Management and Compliance	2012	2013–2015
	Decreasing Non-Emergent Inappropriate Emergency Department Use	2012	2013–2015
	Secondary Prevention by Supporting Families of Children with Attention Deficit Hyperactivity Disorder (ADHD)	2013	2014–2016
	Decreasing Avoidable Hospital Re-admissions	2013	2014–2016
	Increasing Comprehensive Diabetes Testing and Screening	2014	2015–2017
	Improving Postpartum Care	2015	2016-2018
Humana-CareSource	Untreated Depression	2013	2014–2016
	Emergency Department Use Management	2013	2014–2016
	Increasing Postpartum Visits	2014	2015–2017
	HbA1c Control	2015	2016–2018
Passport Health Plan	Reduction of Emergency Room Care Rates	2012	2013–2015[1]
	Reduction of Inappropriately Prescribed Antibiotics for Pharyngitis and Upper Respiratory Infections (URI)	2012	2013–2015[1]
	You Can Control Your Asthma! Development and Implementation of an Asthma Action Plan	2013	2014–2016
	Psychotropic Drug Intervention Program	2013	2014–2016
	Reducing Readmission Rates of Postpartum Members	2014	2015–2017
	Healthy Smiles	2015	2016–2018
WellCare of Kentucky	Utilization of Behavioral Health Medication in Children	2012	2013–2015
	Decreasing Inappropriate Emergency Department Utilization	2012	2013–2015
	Follow-up After Hospitalization for Mental Illness	2013	2014–2016
	Management of Chronic Obstructive Pulmonary Disease (COPD)	2013	2014–2016
	Postpartum Care	2014	2015–2017
	Pediatric Oral Health	2015	2016–2018

[1]Final EQRO review of second re-measurement was sent to MCO 2/24/2015.

The EQRO validation team approach is a key tool used in validating the PIP results, but more importantly, it helps the MCO refine the measurement indicators and study methodology prior to implementation. The MCO benefits from a shared perspective of more than one reviewer. Periodic calls with each MCO to discuss ongoing activities helps the MCO identify problems early and allows for possible revisions. For the collaborative statewide PIPs, the MCOs, DMS and the EQRO also participate in all-plan calls to review study progress collaboratively. DMS intends to produce a report on lessons learned and outcomes from each of the collaborative PIPs as they are finished. They will also post the finished PIPs on the DMS website.

The statewide collaborative PIP offers an opportunity for shared learning and an avenue to address the same message to all MMC providers and members. The CMS Affinity Groups, which Kentucky MCOs are participating in, use a learning collaborative model led by the Center for Health Care Strategies (CHCS). Kentucky MCOs benefit from an opportunity to learn from other states and share promising practices in the areas of antipsychotic medication use, tobacco cessation

and oral health care. Through regular conference call meetings and communication with CMS, Kentucky is establishing a network of partners to improve quality of care in these topic areas.

MCOs interviewed for this evaluation had high praise for the CMS collaborative experience and all commented that this model of shared learning is missing in the Kentucky statewide collaborative PIPs. There have been very few all-plan calls and their content and discussions have not led to any collaboration on the part of the plans. The CMS Oral Health Initiative PIP template was also recognized as a more useful PIP template tool than the EQRO's current PIP tool. Several MCOs also commented on the required six measures for the Safe and Judicious Antipsychotic Medication Use in Children and Adolescents PIP. Three of these measures are not HEDIS-approved measures, and therefore, software for calculating the measures was not available to the MCOs. In addition, five of the six measures are hybrid measures, putting larger burden on providers for medical record requests.

The number of PIPs performed and the duration of a PIP is determined by the state and not mandated by CMS. Kentucky's requirement for MCOs to initiate two new PIPs annually, one of which is the statewide collaborative PIP, was acknowledged as a burden by all MCOs.

Focused Studies of Health Care Quality

Described in federal regulation as an optional quality review activity, the Commonwealth of Kentucky has chosen to include focused studies of health care quality in their Quality Strategy. A focused study examines a particular aspect of clinical or non-clinical service. The EQRO initiates new topic selections by annually developing several proposals that are reviewed and discussed with DMS. DMS chooses two topics annually. All final reports are shared electronically with MCO chief executive officers (CEOs), medical directors, compliance officers and quality managers. The reports are sent with a letter explaining the study and request that the MCO address the recommendations. Final reports are posted on the DMS website and discussed at the MCO quality meetings.

The two study topics for 2015 were medically fragile children and child and adolescent overweight and obesity. Two new topics selected for focused clinical studies in fiscal year (FY) 2016 are emergency department (ED) visits for non-traumatic dental problems and prenatal smoking.

Medically Fragile Children Focused Study, August 2015

This focused clinical study conducted in 2014–2015, had two aims: 1) to profile health care utilization among children in foster care for whom approval for a medically fragile designation has been obtained from DCBS Medical Support Section, and 2) to identify gaps in care coordination and opportunities to improve the performance of the care coordination team (MCO care/case managers, DCBS social workers and nurse consultants with the Kentucky Commission for Children with Special Health Care Needs [CCSHCN]).

The health care utilization profile linked 223 children in foster care who were identified by DCBS as medically fragile with their administrative claims/encounter data records for the study period of 7/1/2013–6/30/2014. Utilization overall and by MCO was profiled for hospitalizations, ED visits, outpatient visits by PCP and specialists and dental visits for medically fragile children compared to all other children. Medically fragile children in the study population identified by DCBS were enrolled in one of the four MCOs: CoventryCares of Kentucky (now Aetna Better Health of Kentucky), Humana-CareSource, Passport Health Plan and WellCare of Kentucky. Qualitative findings were derived from a validated survey instrument, "Relational Coordination Survey for Patient Care"[32] which was modified and used to survey 26 MCO care/case managers, 168 DCBS social workers and 18 CCSHCN nurse consultants. Response rates ranged from 94% for CCSHCN, 69% for MCOs and 53% for DCBS. A review of 105 medically fragile children's case management charts was also conducted and a review of service denials for 21 medically fragile children was performed.

Key findings included:

- Very young children, adolescents and infants comprised the majority of medically fragile children, and most were diagnosed with a complex chronic condition.
- Medically fragile children utilized a disproportionate amount of hospital inpatient and ED services.
- The low relational coordination ranking of PCP and specialist physician providers by all workgroups indicates the need to engage physicians as part of the medically fragile care coordination team.

- Access to and availability of physicians is a barrier to medically fragile child health care coordination.
- Lack of MCO care/case manager access to the foster parent is a barrier to MCO provision of care coordination for medically fragile children.
- There is a lack of MCO engagement as part of the medically fragile child health care coordination team.
- Excessive medically fragile child health care caseload is a prime concern for DCBS, but not MCOs.

As a result of these findings, several recommendations were proposed. DMS was encouraged to continue to work with the MCOs to improve access and availability for medically fragile children to both physical and behavioral health providers. It was suggested that DMS convene a collaborative workgroup of lead MCO, DCBS and CCSHCN care/case managers to further identify the specific provider specialties with barriers to access for medically fragile children. The workgroup could also develop associated communication tools for ongoing monitoring of case management and coordinate collaborative quality improvement activities.

DMS actions regarding the recommendations have been thorough. DMS has conducted additional access and availability studies including behavioral health and dental providers, and is performing a more in-depth review of call dispositions that were not able to schedule any appointment or an appointment in the time required by the standards. DMS is also starting to analyze full-time-equivalents for physicians who have more than one office and are considering the feasibility of applying street-level rather than direct distance ("as the crow flies") parameters for access and availability reviews.

Also in response to recommendations, the Disease and Case Management Branch formed a workgroup to improve access and availability for medically fragile children (referred to here as the Medically Complex Children Workgroup) which met for the first time in December 2015 and is intended to meet quarterly going forward. The workgroup included staff members from the MCOs, DMS, DCBS, CCSHCN, and the EQRO. Discussion at this first meeting led to the following agreements and actions:

- DMS compiled a list of MCO contacts regarding medically complex children and shared them with DCBS and the CCSHCN.
- When DCBS staff identifies a medically complex child, DMS staff is advised and DMS forwards that information to the MCO. DCBS also agrees to notify DMS when a medically complex child is discharged, which is also forwarded by DMS to the MCO.
- A monthly list of medically complex children will be sent from DCBS to DMS, who will separate the members by MCO and share with the respective MCO contact for the workgroup on medically complex child health care.
- All medically complex children will be referred to MCO case management.
- The service plans for medically complex children will be closely monitored and either manually or electronically signed by an MCO representative.
- Monthly DCBS/MCO meetings will include medically complex children as an agenda item.

MCOs commented that they continue to have monthly meetings with DCBS and that the first meeting of the Medically Complex Children Workgroup was quite productive, but there has not been a follow-up meeting.

Assessment, Prevention and Treatment of Child and Adolescent Overweight and Obesity Among the Kentucky Medicaid Managed Care Population, Clinical Focus Study 2015, September 2015

This focused study was a retrospective review of medical records of children and adolescents enrolled in Kentucky MMC. The purpose of the study was to assess the implementation of the Expert Committee guideline recommendations[33] for the prevention, identification, assessment and treatment of overweight and obesity among children. A random sample of eligible enrollees who turned 2–18 years old during the measurement year, November 1, 2013 to October 31, 2014, was selected from the five MMC plans: Anthem BCBS Medicaid, CoventryCares of Kentucky (now Aetna Better Health of Kentucky), Humana-CareSource, Passport Health Plan and WellCare of Kentucky. The final study sample of 668 was fairly evenly distributed by age group with 217 preschool children, 225 school-age children and 226 adolescents.

Key findings included:

- While BMI value or percentile was appropriately documented for older adolescents, BMI percentile documentation was present for only 49% of younger children.

- Risk assessment was lacking in medical record documentation, with only 57% of records including family history and 29% including plotting of BMI on a growth chart.
- Less than half of the members in the study sample had nutritional counseling (47%) or physical activity counseling (41%), and most counseling was not specific to risk behaviors.
- Obesity was noted to be particularly prevalent in the adolescent age group (30%), but 17% of preschool children were also noted to be obese.
- Most records of overweight and obese children did not include appropriate laboratory testing for obesity-related conditions, and risk behavior assessment was not universally documented.
- Most records of at-risk overweight and obese children and adolescents did not include assessment of risk behaviors or behavioral or weight goals; only 5% included a scheduled follow-up of weight status, and only 2% included any structured, higher intensity interventions.

The study recommendations encouraged MCOs to promote BMI percentile screening and universal prevention interventions for all MMC-enrolled children beginning in early childhood; to improve provider risk assessment, management and monitoring of overweight and obese enrollees; to ensure that resources for nutrition, physical activity and weight management are disseminated to network providers; and to educate members and families regarding cardiovascular and other health risks associated with overweight and obesity. It was further recommended that improvement efforts address obesity with a chronic care model that includes motivational interviewing, family involvement and engagement of all office staff in the care of at-risk children and adolescents.

In response to these study findings, DMS intends to use their HEDIS Measures Incentive Program to encourage follow-up by the MCOs. As part of the incentive program, all of the HEDIS measures for Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents will earn performance and improvement incentives.

Since this focused study required medical record reviews, MCOs again expressed their concern in terms of the medical record request burden they are placing on their providers. It was suggested that DMS and the EQRO plan the timing of focused studies that require medical record reviews so that they are not added to the provider's burden for medical records during HEDIS and PIP measurement periods.

Emergency Department Visits for Non-traumatic Dental Problems among the Adult Kentucky Medicaid Managed Care Behavioral Health Subpopulation

This study utilized administrative encounter data to identify risk factors for ED visits for non-traumatic dental problems (NTDV), an indicator of unmet dental need, among the adult Kentucky MMC behavioral health (BH) subpopulation. The report was submitted to DMS on May 19, 2016. Novel findings shed light on the potential for health system and provider interventions to improve access to and quality of dental care. Members who had an outpatient dental visit for pain/palliative care, but who did not receive treatment, had more than three times greater odds for a subsequent NTDV event compared to the members who received outpatient dental treatment. The study concluded that unmet dental need is a substantial problem for the Kentucky MMC BH subpopulation, and a driver of costs attributable to NTDVs. Improving access to preventive and treatment-based outpatient dental care holds the potential to reduce unnecessary ED visits and improve the health of this vulnerable subpopulation, as well as generate considerable cost savings. Recommendations emphasized that enhanced care coordination that facilitates access to PCPs, BH providers, as well as dentists, is merited. MCOs should consider the risk factors identified in this study for targeting care management interventions, as well as investigate patterns of multiple hospital ED use. Specific recommendations were made for plans to develop partnerships with academic medical centers for implementation of ED dental diversion programs in urban areas, as well as evaluate dental networks in rural and Appalachian counties, and undertake initiatives to improve access and availability of dental providers.

Prenatal Smoking

This study profiled smoking prevalence, member characteristics, receipt of prenatal smoking cessation services and perinatal outcomes among the Kentucky MMC population who delivered a singleton live or non-live birth. Provider prenatal and postpartum interventions and case management interventions were also profiled, including whether smoking abstinence was achieved. Data for the study were derived from two sources: 1) administrative encounter data to define the eligible population; and 2) medical chart and case management record reviews of a random sample of 400 members. The report was submitted to DMS on June 9, 2016. Findings showed that many prenatal smokers enrolled in

Kentucky MMC did not receive American College of Obstetricians and Gynecologists (ACOG)-recommended smoking cessation interventions from providers. With few exceptions, neither prenatal care providers nor MCO care managers referred prenatal smokers to the Kentucky quit line. What's more, there were considerable missed opportunities for care managers to identify, contact and engage prenatal smokers in smoking cessation programs early in the pregnancy, as well as missed opportunities to contact prenatal care providers for coordination of smoking cessation interventions. Consequently, only a handful of pregnant smokers achieved smoking abstinence during the critical prenatal period. Recommendations emphasized that DMS can provide guidance to the plans by initiating a statewide collaborative PIP for prenatal smoking cessation and by working with the plans to address prenatal access and availability issues, in accordance with the specific MCO recommendations outlined in the report.

Financial Incentives

Many state MMC programs across the country use some form of incentive or sanction to encourage quality performance. In the states reviewed for this summary, New York, Maryland and New Jersey have a Pay for Performance (P4P) incentive. Florida's Quality Strategy, on the other hand, describes a Performance Measure Sanction Strategy to financially penalize MCOs for failing to reach benchmarks. California selects priority focus areas and sets performance targets for its MMC plans and will impose sanctions, including financial penalties, to plans under a CAP that do not meet established milestones.

Kentucky recently revised the MMC Contract to include language describing their newly proposed HEDIS Measures Incentive Program. Funded from a pool created by withholding a percent of the capitation payments, this incentive program seeks to improve statewide quality performance for all HEDIS measures. In the initial incentive period, from July 1, 2015 through December 31, 2015, the incentive pool will be funded with 1% of the capitation payments; and thereafter, by calendar year, the pool will increase by 0.25%, not to exceed a maximum of 2%. There are two types of awards: 1) a performance incentive and 2) an improvement incentive. To be eligible to receive a performance incentive, the MCO is required to have submitted HEDIS data for the calendar year for the incentive period. To be eligible for the improvement incentive, the MCO must have submitted HEDIS data for the calendar year of the incentive period and the preceding year.

MCOs will earn shares based on the number of HEDIS measures (at or greater than the 50th, 75th or 90th percentile) plus for each 2 percentage increase in a measure between the incentive period and the preceding year. The incentive pools will be divided between the MCOs based on the proportion of shares received. The contract language for the incentive program provides a series of examples to demonstrate how the incentive and payout amounts will be calculated.

In addition to the withholds/penalties DMS has in place for encounter data submissions and for failure to correct CAPs, DMS is pleased to initiate this incentive program as a positive re-enforcement of the importance of quality performance in the Kentucky MMC Program. MCOs commented that conceptually, being rewarded for good performance is a good idea, but there was some uncertainty about how the incentive would be operationalized. The MCOs understand that it will be their responsibility to determine which measures they need to improve and how they will mobilize resources to achieve the targets.

MCOs commented that they were anticipating more specific information on the incentive program, but conceptually they expressed optimism that P4P programs were positive methods of driving improved performance. With all HEDIS measures included in the program, several MCOs acknowledged that in order to maximize their share of the payout pools, deciding where to invest their quality improvement resources would be critical.

Strengths, Opportunities for Improvement and Recommendations

The strengths and opportunities for improvement in Kentucky's MMC Program are presented in this section as a culmination of this comprehensive evaluation summary. The Commonwealth of Kentucky's Strategy for Assessing and Improving the Quality of Managed Care Services (September 2012) was the basis for this evaluation of program accountability, monitoring mechanisms and compliance assessment systems.

Strengths

Program Administration

- The Commonwealth of Kentucky's Strategy for Assessing and Improving the Quality of Managed Care Services was approved by CMS in September 2012 and included all required elements, which were adequately described.
- Kentucky continues to have a contract in place for external quality review, including work plan activities for the annual technical report, the three mandatory quality review activities and several optional activities, such as conducting focused quality studies and validation of MCO submitted data files.
- With several leadership changes and increasing branch responsibilities for monitoring and quality improvement, DMS continues to vigorously apply staff resources and expertise in the development of their expanding MMC Program.
- DMS applied for and received acceptance to participate in several CMS Affinity Group collaboratives and a SAMHSA Tobacco Policy Group collaborative, which offer opportunities to expand state resources through collaboration with other state and national participants.
- All required data collection systems are in place and data submissions are occurring according to schedule.
- MCOs commented that their communication with DMS regarding encounter data submissions continues to be positive and the monthly conference calls with DMS continue to be helpful.
- DMS continues to update their internet website to include MCO data reports and external quality review reports.

Goals and Benchmarks

- For HEDIS 2015, the following measures met or exceeded the 2012 national benchmark:
  - Breast Cancer Screening
  - CDC: Hemoglobin A1c Testing
  - CDC: Medical Attention for Nephropathy
  - Antidepressant Medication Management: Effective Acute Phase
  - Antidepressant Medication Management: Effective Continuation Phase
  - Children and Adolescents Access to Primary Care for ages 7–11 years and ages 12–19 years
  - Outpatient Visits for all age groups.

Quality Monitoring and Assessment

- Kentucky's MMC Program is composed of five MCOs. Program enrollment grew by 4.8% from 1,174,716, in April 2015 to 1,231,505 in April 2016.
- In an effort to streamline reporting requirements, DMS convened a workgroup to review and make changes to the reports MCOs are required to submit monthly, quarterly and annually. As a result, a revised Appendix K was drafted and lists 68 (or 45%) of the originally listed reports as "inactive." Some reports have been changed from monthly to quarterly and some reports were revised to provide better and more accurate data.
- An annual health plan report card entitled "A Member's Guide to Choosing a Medicaid Health Plan" was prepared for 2015 open enrollment. It was also posted on the DMS website.
- Using HEDIS 2015 data, the EQRO prepared a quality performance dashboard as an internal monitoring tool for DMS.
- DMS continues to prepare a monthly MCO dashboard using data submitted in MCO monthly reports.
- EQRO monitoring continues to provide annual MCO compliance reviews, monthly encounter data validation reports, provider network validations, MCO web-based provider directory validations, access and availability surveys and Kentucky performance measurement validations.
- The EQRO's quarterly desk audits allow the MCO to address issues during the year rather than during or after the compliance review is completed.

- According to the EQRO review of Kentucky EPSDT for 2014, all five MCOs showed evidence of a sufficient network of EPSDT providers. MCOs continue to implement a variety of initiatives to improve EPSDT screening, including educating and outreaching to members, educating providers and facilitating EPSDT service through several innovative member outreach efforts.
- The annual technical report continues to meet federal regulations and provides a useful summary of external quality review findings related to access, timeliness and quality of care.
- There is a good working relationship between the state, EQRO and the MCOs. DMS and the EQRO continue to facilitate numerous workgroups and regularly scheduled meetings to discuss program progress and resolve issues.

Quality Improvement

- The EQRO continues to effectively validate MCO PIPs using an established process that includes proposal review, ongoing progress, re-measurement and final report.
- Two statewide, collaborative PIPs are ongoing. Initiated in 2014, "Safe and Judicious Antipsychotic Medication Use in Children and Adolescents" is in its second year and the 2015 PIP "The Effectiveness of Coordinated Care Management on Physical Health Risk Screenings in the Seriously Mentally Ill Population" is in development.
- Two focused clinical studies were completed in 2015: the Kentucky Medically Fragile Children Focused Study and Assessment, Prevention and Treatment of Child and Adolescent Overweight and Obesity among the Kentucky Medicaid Managed Care Population.
- Additional two focused studies were completed in 2016: Emergency Department (ED) Visits for Non-traumatic Dental Problems Among the Adult Kentucky Medicaid Managed Care Behavioral Health Subpopulation and Prenatal Smoking.
- A HEDIS Measures Incentive Program was drafted.

Opportunities for Improvement

Program Administration

- Kentucky's Quality Strategy is due to be updated. DMS plans to update the Quality Strategy to reflect the kyhealthnow 2019 goals. The update is expected to be completed by the end of 2016.
- DMS's medical director position is currently vacant. In DPQ&O, the assistant director position is vacant. A number of staff vacancies also exist including a nurse/consultant inspector position in the Disease and Case Management Branch and one internal policy analyst III position in the Contract Compliance Branch.
- Coordination opportunities still exist between DMS, the MCOs and other state agencies, including DCBS, DAIL and DBHDID, to address and improve care coordination for foster children, aged members and individuals with behavioral health, developmental and intellectual disabilities.
- To further assist MCOs in tracking and improving their encounter data completeness, DMS should consider sharing the monthly EQRO encounter data validation reports with the MCOs.
- DMS, in collaboration with the EQRO and with input from the MCOs, revised the content and format of the annual report card. Going forward, DMS may want to research various other options for content and format to determine what their members would prefer. Conducting member focus groups is one way to obtain their input and perspectives. Researching what other states present in an annual report could also be pursued.

Goals and Benchmarks

- Over the past two years, the number of Quality Strategy measures that met or exceeded the 2012 Medicaid national benchmark rates fell from 17 (60.7%) in HEDIS 2014 to only 8 measures (38.1%) in HEDIS 2015.
- Opportunities for improvement are evident for the following measures with declining rates of performance from baseline to HEDIS 2015 re-measurement:
  - Cervical Cancer Screening
  - CDC: Eye Exam Performed
  - Follow-up After Hospitalization for Mental Illness Within 30 Days of Discharge and Within 7 Days of Discharge
  - Adult Access to Preventive/Ambulatory Health Services, all age groups
  - Children and Adolescents Access to Primary Care, ages 12–24 months and ages 25 months to 6 years.
- HEDIS 2015 measures for Follow-up After Hospitalization for Mental Illness Within 7 and 30 Days of Discharge were markedly below the HEDIS 2012 national benchmark by as much as 26.8 and 23.9 percentage points, respectively.

- Kentucky's Quality Strategy could be strengthened by adding goals for prenatal/postpartum care and childhood preventive health. Additional measures related to kyhealthnow 2019 goals would include enrollment growth, smoking cessation, cardiovascular care, overweight and obesity for children and adults, substance abuse, poor mental health and dental care for children and adults.
- For an updated Quality Strategy, the benchmark rates should be revised to reflect the kyhealthnow 2019 goals.

Quality Monitoring and Assessment

- The process of summarizing selected quarterly report information across plans in the form of quarterly desk audits highlights the variability in the data reported and raises questions about how each of the MCOs are interpreting the questions. More data specification and interpretive guidance is needed, so that all MCOs are reporting consistently and a fair comparison can be made across plans.
- Providing interpretive guidance and more data specification for all required monthly, quarterly and annual reports, including data sources to be used, would help improve the consistency in MCO reporting. DMS feedback and comments regarding MCO quarterly report information would also be helpful.
- Results of the PCP Access and Availability Survey indicated that only 31.8% of the calls for routine visits received an appointment within the standard time frame; 24.8% of the calls for non-urgent care received an appointment within the standard time frame and 52.0% of the after-hours calls were compliant. All rates are substantially below the standard of 80%.
- Results of the Dental Access and Availability Survey indicated that only 35.2% of the dentists called for a routine appointment were able to be contacted and an appointment made within the timeliness standards of the contract. For urgent appointments, only 31.6% of the dentists were compliant. Both rates are substantially below what would be expected.
- As of September 2015, less than 1% of Kentucky MMC enrollees were enrolled in an MCO case management program and another 8.26% were enrolled in an MCO disease management program.
- Reported EPSDT screening rates dropped from 83% in RY 2015 to 82% in RY 2015. The reported participation rate for EPSDT services in RY 2015 was 58%, well below the 80% standard set by CMS. Results of the EPSDT validation study and HEDIS and Healthy Kentuckians measures indicated opportunities for improvement in mental health, vision, hearing, and developmental screening; depression and behavioral risk screening for adolescents; BMI screening and nutrition/physical activity counseling; immunizations and lead screening. Oral health assessment was also found lacking in the validation study.
- Meeting notes are not always prepared and distributed, especially for the encounter data meetings. Several MCOs also commented on the value of face-to-face meetings over conference calls whenever possible.

Quality Improvement

- MCOs continue to express concern about the quantity of PIPs that are ongoing at any one time (as many as four to six), which places a burden on MCO resources and may result in fewer or less aggressive interventions.
- The CMS collaborative experiences offer a model of shared learning that is missing in the Kentucky statewide collaborative PIPs. There have been very few all-plan calls and their content and discussions have not led to any collaboration on the part of the plans.
- The CMS Oral Health Initiative PIP template was recognized by the MCOs as a more useful PIP template tool than the EQRO's current PIP tool.
- As a result of the Medically Fragile Children Focused Clinical Study, DMS was encouraged to continue to work with the MCOs to improve access and availability for medically fragile children to both physical and behavioral health providers.
- As a result of the Assessment, Prevention and Treatment of Child and Adolescent Overweight and Obesity Clinical Focused Study, MCOs were encouraged to promote BMI percentile screening and universal prevention interventions for all MMC-enrolled children beginning in early childhood; to improve provider risk assessment, management and monitoring of overweight and obese enrollees; to ensure that resources for nutrition, physical activity and weight management are disseminated to network providers; and to educate members and families regarding cardiovascular and other health risks associated with overweight and obesity. It was further recommended that improvement efforts address obesity with a chronic care model that includes motivational interviewing, family involvement and engagement of all office staff in the care of at-risk children and adolescents.

- In consideration of the medical record request burden placed on MCOs during HEDIS and PIP studies, it is suggested that DMS and the EQRO plan the timing of focused studies requiring medical record reviews so that they do not add to the provider's burden for responding to medical record requests during HEDIS and PIP measurement periods.
- With Kentucky's HEDIS Measures Incentive still to be implemented, there remains some uncertainty among the MCOs about how the incentive will be operationalized. Good communication and data transparency are important in rolling out the incentive program.

Recommendations

- The Kentucky Quality Strategy should be updated. DMS should consider adding goals and objectives for childhood preventive health, prenatal/postpartum care and other measures identified in kyhealthnow 2019 goals. DMS should re-evaluate how benchmarks or other targets for improvement can be applied.
- DMS should consider enhancing the statewide collaborative PIP process by adopting a learning collaborative model to include more all-plan conference calls and learning sessions with experts in the field of behavioral health, coordinated care management and antipsychotic medication use by children and adolescents. MCOs should be encouraged to engage partners in conducting their interventions, including other MCOs, community-based organizations or national organizations that focus on child and adolescent behavioral health.
- DMS should continue to collaborate with MCOs in the review of program monitoring and reporting requirements.
- Learning from the experience in other states, DMS may want to further augment their focus on quality improvement by offering more technical assistance and feedback to the MCOs regarding HEDIS rate improvement, including face-to-face conferences and trainings based on lessons learned from focused quality studies and PIPs. Data transparency and communication through the state website and other social media forums can also be useful educational tools.

Attachment A: Selected Quality Improvement Initiatives from Other States

Extracted from State Quality Strategies:

State (Program Name)	Quality Improvement Initiatives
New York State[34] Year of Strategy: July 2014 Administered by: Office of Quality and Patient Safety, NYS Department of Health (NYS DOH) Medicaid and CHIP Enrollment* Jan. 2016 (Prelim): 6,431,583	Prevention Quality Indicators The PQIs are a set of measures developed by the Agency for Healthcare Research and Quality (AHRQ) to identify ambulatory care sensitive conditions. These are conditions for which good outpatient care can potentially prevent the need for hospitalizations, or for which early intervention and treatment would prevent complications or severe disease. While the hospital admission is used to identify the PQI, the PQIs can be used to flag problems in the health care system outside the hospital. Each year, the NYS DOH calculates plan-specific adult and pediatric PQI reports which are sent to the health plans. These reports also include enrollee characteristics and PQI rates by hospital. Health plans with a PQI rate higher than the statewide average are required to respond to NYS DOH with a root-cause analysis and action plan. Quality Improvement plan managers at the Office of Quality and Patient Safety (OQPS) oversee the response process and offer guidance on best practices to improve PQI measured performance. Collaborative PIPs Medicaid managed care plans are required to conduct one PIP annually using a report template that reflects CMS requirements for a PIP. In the past, each plan chose a topic, and with the technical assistance from the EQRO, developed a study methodology and conducted interventions to reach their improvement goals. More recently, the NYS DOH has encouraged plans to participate in collaborative PIP studies. From 2009-2010, 18 plans worked with NYS DOH and the EQRO to improve the prevention of childhood obesity. From 2011-2012, ten plans worked on addressing potentially preventable hospital readmissions, and six plans worked to reduce disparities in asthma care by partnering with health care practices in Central Brooklyn. The 2013-2014 PIP addresses diabetes management and prevention, hypertension, and smoking cessation. One component of this PIP is the Medicaid Incentives for the Prevention of Chronic Disease (MIPCD) grant, in which New York is participating alongside ten other states to determine the effect of offering financial incentives as a means of engaging recipients in preventive health services. Pay for Performance – Quality Incentive In 2002, the NYS DOH began rewarding plans for superior performance by adding up to three percent to the plan's per-member, per-month premium. This Quality Incentive (QI) program uses a standardized algorithm to award points to health plans for high quality in the categories of: Effectiveness of Care, Access and Availability, and Use of Services. Points are deducted for any Statements of Deficiency (SOD) issued for lack of compliance with managed care requirements. Assessments of quality and satisfaction are derived from HEDIS measures, CAHPS satisfaction data, and PQIs. Quality Performance Matrix In order to monitor health plan performance on quality measures, a quality performance matrix was developed and

State (Program Name)	Quality Improvement Initiatives
	implemented in 1998. The matrix approach provides a framework for benchmarking performance and helps plans prioritize quality improvement planning. The matrix gives a multi-dimensional view of plan performance by comparing rates for selected measures in two ways: 1) to the statewide average and 2) a trend over two years. The result is a 3x3 table where measures are displayed in cells corresponding to a letter grade ranging from A (best performance) to F (worst performance). Plans are instructed to conduct a root-cause analysis and action plan for any measure where there is poor performance based on the barriers identified. The action plans are reviewed and approved by DOH staff and are monitored throughout the year to assure that they are being conducted and evaluated for effectiveness in improving performance. Publication of Quality Performance Reports Reports on Medicaid quality performance, patient satisfaction, health plan comparisons, enrollment, quality improvement initiatives, and research results are made available online at: http://www.health.state.ny.us/health_care/managed_care/reports/index.htm. These easy-to-read reports are designed to help members choose a health plan that meets their needs and the needs of their families, and to inform stakeholders. Data is provided for commercial and government-sponsored managed care. Published reports also include results from External Quality Review of the MMC program. Journal articles are submitted to peer review journals publishing health plan quality performance. Quality Improvement Conferences and Trainings NYS DOH is committed to providing MMC plans with tools to conduct successful quality improvement initiatives. One successful approach has been the sharing of other plan experiences in best practice forums. NYS DOH, in collaboration with its EQRO, has conducted conferences on immunization strategies, partnering for quality improvement, understanding CAHPS (consumer survey) results, adolescent preventive care, physician profiling, ADHD, childhood obesity, asthma, diabetes, and prenatal care. Conferences are also held upon completion of collaborative PIPs. Evaluation feedback is always sought and comments are used in planning future events. Plan Manager Technical Assistance Each plan is assigned a DOH plan manager. They provide technical assistance to plan staff as they develop their root-cause analyses and action plans in response to the Quality Performance Matrix and PQI measures. They prepare a plan's Quality Profile for the area office staff prior to their conducting an on-site Compliance Review survey. They also consult with plans concerning their PIPs.
California[35] Annual Assessment of Strategy: Nov 2015; Revised: Feb 2016 Administered by: Dept. of Health Care Services (DHCS)	QI training Many forms of QI education and training are implemented throughout the Department to equip staff with the skills they need to advance quality system-wide. For example, the Office of Workforce Planning and Development coordinates a full-day training on Lean methodologies to improve business processes in government. The Medi-Cal Adult Quality Care Improvement Initiative is providing training on the core principles of QI and a longitudinal course in the application of QI methodology among a cross-section of DHCS clinicians and staff, who are working to improve diabetes and maternal care for Medi-Cal recipients. DHCS hosts a monthly learning series, journal club, and book club to foster scientific and policy dialogue and to inspire innovation in health care quality.

State (Program Name)	Quality Improvement Initiatives
Medicaid and CHIP Enrollment* Jan. 2016 (Prelim): 12,259,866	Focus on Priority Areas Quality Strategy focuses on the following: two chronic disease areas (diabetes and hypertension), two services within maternal/child health (postpartum care and immunization of two year olds) and tobacco cessation. Objectives are set for each measure for a 5 percentage point improvement over the baseline year of measurement year 2013. DHCS closely monitors Medi-Cal Managed Care plan interventions throughout the year and requires managed care plans to use rapid-cycle improvement initiatives (PDSA). DHCS staff provides in-depth technical assistance to help plans identify barriers, develop root cause analyses and implement quality improvement initiatives. New PIP Process Beginning in September 2015, managed care plans will be required to use rapid-cycle improvement methods to pilot small changes. The EQRO developed a series of five modules which follow a framework based on a modified version of The Institute for Healthcare Improvement's (IHI) Model for Improvement. The EQRO will provide technical assistance throughout the process with frequent contact and feedback. PIPs will last 18 months with the first topic being one of four preselected DHCS topics that align with the state's priority focus areas. The second PIP topic will be selected by the managed care plan. The following four Quality Improvement Collaboratives were established: Diabetes Quality Improvement Collaborative; Hypertension Quality Improvement Collaborative; Postpartum Quality Improvement Collaborative and the Quality Improvement Learning Collaborative. Public Reporting of Performance Results Publically reports audited performance results for each plan on its website and in frequent presentations to stakeholders. The Medi-Cal Managed Care Performance Dashboard displays data on enrollment and demographics, financial strength of plans, health care service utilization, grievances and state Fair Hearings, continuity of care and medical exemption requests and HEDIS and CAHPS rates. In March 2015, DHCS and the California Health and Human Services (DHHS) implemented an Open Data Portal which facilitates public access to non-confidential health and human services data.
Florida[36] Year of Strategy: 2014 Administered by: Agency for Health Care Administration (AHCA) Medicaid and CHIP Enrollment* Jan. 2016 (Prelim): 3,576,943	Use of Social Media The Agency for Health Care Administration uses profiles on Facebook, Twitter, YouTube and SlideShare to engage with stakeholders at all levels. Hosting these sites allows the Agency to share news and events with legislators, state and federal agencies and healthcare providers as well as respond to questions and concerns from both providers and recipients. These platforms have resulted in over 193,000 views of Agency slideshow presentations, nearly 14,000 views of the Agency's instructional videos, and dozens of direct interactions with Medicaid providers and recipients. The Agency will continue to foster relationships using social media as part of its ongoing pursuit of its mission, "Better Health Care for All Floridians." Quality Performance Measure Sanction Strategy Written into the 2012-2015 HMO and Provider Service Network (PSN) contracts, the Performance Measure Sanction Strategy applies sanctions based on managed care plans' performance measure submissions. The key provisions of the sanction strategy are as follows: • For the 2012 measurement year, each performance measure (PM) was assessed a score based on its ranking relative to the

State (Program Name)	Quality Improvement Initiatives
	national 50th percentile. A seven point scoring system is used (0-6). • The PMs were combined into groups of similar PMs. The PM groups receive an average PM group score. The PM groups are: Mental Health and Substance Abuse; Well-Child; Prenatal/Postpartum; Chronic Care; Diabetes; and Other Preventive Care. • Managed care plans were required to develop and submit Performance Measure Action Plans (PMAPs) for any HEDIS measure where the plan's score falls below the 50th national percentile. The managed care plans submit quarterly reports describing their progress with details on the interventions being used to improve care and their performance. Common intervention strategies include enrollee and provider outreach and education, enhanced disease management programs, incentives for compliance with preventive and routine care, and strengthening the role of quality staff. PMs were included in determinations of sanctions after the health plan developed and implemented a PMAP. • For the 2013 performance measure submission, PM group sanctions were assessed for PM group scores that fell below the equivalent of the 50th national percentile. Managed care plans were sanctioned up to $10,000 per PM group score that fell below the threshold national percentile. • Individual measure sanctions for measures in the Mental Health and Substance Abuse, Chronic Care, and Diabetes groups may be applied if the health plan's rate falls below the equivalent of the 10th national percentile. PIPs With the implementation of the Statewide Medicaid Managed Care program, the Managed Medical Assistance plans are required to perform 4 Agency-approved performance improvement projects. Two PIP topics are state-mandated: one PIP combines a focus on improving prenatal care and well-child visits in the first fifteen months, while the other PIP focuses on preventive dental care for children. A third PIPs is an administrative/non-clinical PIP and the fourth PIP is selected from one of the following topic areas: population health issues (such as diabetes, hypertension and asthma) within a specific geographic area that is identified as in need of improvement; integrating primary care and behavioral health; or reducing preventable readmissions. NCQA Accreditation As a condition of participation in the Statewide Medicaid Managed Care program, all managed care plans are required to be accredited by the National Committee for Quality Assurance (NCQA), the Accreditation Association for Ambulatory Health Care, Inc. (AAAHC), or another nationally recognized accrediting body, or have initiated the accreditation process within one year after their contract with the Agency is executed. For any health plan not accredited within 18 months after contract execution, the Agency will suspend automatic assignment of recipients to those managed care plans. Achieved Savings Rebate In order to ensure that capitated payments made to plans participating in the Statewide Medicaid Managed Care (SMMC) program are appropriate, the Agency implemented a statutorily defined program called the Achieved Savings Rebate program. This program includes enhanced financial monitoring of plans and plan expenditures through submission of detailed financial reporting by plans and an annual audit of that documentation conducted by an independent certified public accountant. The independent auditor will determine the achieved savings of each plan. This program includes the incentive that a plan which exceeds Agency-defined quality measure benchmarks in the reporting period may retain an additional one percent of revenue.

State (Program Name)	Quality Improvement Initiatives
	In order to retain the one percent incentive, plans must achieve a group score of four or higher for each of the six performance measure groups in the first year of reporting performance measures. Consumer Report Card Florida is developing a consumer report card for the plans that will be participating in the Statewide Medicaid Managed Care program. This new initiative will provide valuable feedback to the plans and the public on the performance of all Medicaid managed care plans. Medical Schools Quality Network The Statewide Medicaid Managed Care statute required that the Florida Medicaid program contract with a single organization representing medical schools and graduate medical education programs in the state for the purpose of establishing an active and ongoing program to improve clinical outcomes in all managed care plans. Contracted activities must support greater clinical integration for Medicaid enrollees through interdependent and cooperative efforts of all providers participating in managed care plans.
Maryland[37] (Maryland HealthChoice) Year of Strategy: June 2015 Administered by: Dept. of Health and Mental Hygiene Medicaid and CHIP Enrollment* Jan. 2016 (Prelim): 1,159,510	Value Based Purchasing (VBP) The HealthChoice Value Based Purchasing Initiative improves quality by awarding financial incentives to MCOs based on their performance. Maryland's VBP strategy aims to better coordinate a variety of quality improvement efforts toward a shared set of priorities that focus on the core populations served by HealthChoice. The Department and its stakeholders identify legislative priorities in selecting the performance measures. The performance measures are from HEDIS measures and encounter data. Measures may be added or removed, based upon evolving priorities and participant health care needs. The Department uses a standard methodology to calculate the incentive, neutral, and disincentive ranges, based on previous MCO performance in HEDIS and encounter data measures. Consumer Report Card The Consumer Report Card assists Medicaid participants in selecting one of the participating HealthChoice MCOs. Information in the Report Card includes performance measures from HEDIS, the CAHPS survey, and the Value Based Purchasing Initiative. There are six reporting categories, with one level of summary scores for each reporting category. Three stars represent performance that is above the Maryland HealthChoice average; two stars for the same as the Maryland HealthChoice average; or one star for below the Maryland HealthChoice average. Patient Centered Medical Home In 2011, Maryland began a three-year pilot program to test the use of a patient-centered medical home (PCMH), called the Maryland Multi-Payer Patient-Centered Medical Home Program (MMPP). The MMPP provides Maryland patients with many services, such as integrated care plans, chronic disease management, medication reconciliation at every visit, and same-day appointments for urgent matters. Across Maryland, 52 primary practices, multispecialty practices, and federally qualified health centers participate in MMPP. These practices are paid through HealthChoice MCOs and private insurance carriers, depending on their patient population.

State (Program Name)	Quality Improvement Initiatives
	Chronic Health Home Demonstration In the FY 2013 budget, the Maryland General Assembly set aside funds for the development of a chronic health home demonstration; The Department partnered with the Center for Chronic Disease Prevention and Control (CCDPC) in their Million Hearts effort. Million Hearts in Maryland set out to improve clinical and community linkages through the use of community health workers and community referrals. CMS's State Innovation Models (SIM) Initiative With the help of the SIM planning grant, Maryland developed the capacity to use its data resources for community health assessment and planning. Maryland's health information exchange (HIE), known as the Chesapeake Regional Information System for our Patients (CRISP), accesses data in real time from all of Maryland's acute care hospitals and emergency departments. It provides real-time admission data to primary care clinicians thousands of times a day via secure email, in order to improve communication between hospitals and PCPs. Maryland was awarded up to $2.3 million in the first round of the model design program of the SIM Initiative. The Department sought to expand Maryland's community integrated medical homes (CIMH) model by partnering with healthcare providers and community health organizations. The CIMH model focuses on preventive health care and management rather than urgent intervention of serious medical issues.
New Jersey[38] Year of Strategy: June 2014 Administered by: Div. of Medical Assistance and Health Services Medicaid and CHIP Enrollment* Jan. 2016 (Prelim): 1,703,107	Lead Poisoning Surveillance System Medicaid information is matched with the NJ DOH Childhood Lead Poisoning Surveillance System and identification of children who are lead-burdened or in need of lead screening is shared with MCOs for appropriate outreach or follow-up. As a result of this program blood lead screening rates have improved and there is more timely case management of lead burdened children. Care Management Tool The state monitors MCO care management through Focused Chart Audits conducted annually by the EQRO. The records are evaluated for timely outreach, early identification of special needs populations, completion of an initial health screening and a needs assessment and care plan (if necessary), level of care management, preventive services, care of lead-burdened children, adherence to lead screening protocols, appropriate linkages, continuity and coordination of services and discharge planning following hospitalization. Findings are compared to desired performance standards. Performance-Based Contracting (PBC) The performance based contracting program began in July, 2013 to motivate MCOs to improve and sustain improvement in clinical priority areas chosen by the state: birth outcomes, diabetes and obesity. Funding for the incentive is derived by setting aside a portion of the capitation rate and a revision of the associated efficiency expectations in SFY 2015. MCOs earn PBC amounts based on improved performance measure results from baseline (CY2013) to measurement year.

*Source: Centers for Medicare and Medicaid Services, accessed 4/26/2016. https://www.medicaid.gov/medicaid-chip-program-information/program-information/downloads/january-2016-enrollment-report.pdf

References

[1] http://www.ecfr.gov/cgi-bin/text-idx?c=ecfr&sid=b4058b30e1d1a47b9abd147b7dced4cc&rgn=div5&view=text&node=42:4.0.1.1.8&idno=42#PartTop. Accessed June 6, 2016

[2] http://www.ssa.gov/OP_Home/ssact/title19/1915.htm. Accessed June 6, 2016.

[3] http://www.ssa.gov/OP_Home/ssact/title19/1932.htm. Accessed June 6, 2016.

[4] http://www.govtrack.us/congress/bills/105/hr2015. Accessed June 4, 2016.

[5] http://www.ecfr.gov/cgi-bin/text-idx?c=ecfr&sid=b4058b30e1d1a47b9abd147b7dced4cc&rgn=div5&view=text&

node=42:4.0.1.1.8&idno=42#PartTop. Accessed June 4, 2016.

[6] Medicaid and CHIP Managed Care Final Rule, April 25, 2016: https://www.federalregister.gov/articles/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered. Accessed June 6, 2016.

[7] Medicaid and State Health Care Reform: Process, Programs and Policy Options. Suzanne Rotwein Ph.D., Maria Boulmetis, MAS, Paul J. Boben, Ph.D., Helaine I. Fingold, J.D., James P. Hadley,MA, MHS, Kathy L. Rama, BA, Debbie Van Horn, MAS. Health Care Financing Review. 1995 Spring; 16(3): 105-120. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4193511/. Accessed June 6, 2016.

[8] Centers for Medicare and Medicaid Services website: https://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/prevention.html Accessed on June 6, 2016.

[9] NCQA Quality Compass, available for purchase at: http://www.ncqa.org/HEDISQualityMeasurement/QualityMeasurementProducts/QualityCompass.aspx. Accessed June 6, 2016.

[10] According to NCQA contract stipulations, we cannot publish NCQA Quality Compass percentile rates.

[11] Centers for Medicare and Medicaid Services: https://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/quality-strategy-toolkit-for-states.pdf. Accessed June 6, 2016.

[12] kyhealthnow 2019 goals: http://migration.kentucky.gov/Newsroom/governor/20140220kyhealthnow.htm. Accessed June 6, 2016.

[13] Unbridled Health, A Plan for Coordinated Chronic Disease Prevention and Health Promotion, 2012 – 2016: http://chfs.ky.gov/nr/rdonlyres/edc31b0e-d81e-4bb0-87cd-ec3cccc837f9/0/unbridledhealthplannovember2013.pdf. Accessed June 6, 2016.

[14] State Innovation Model (SIM) Model Design Grant, State Health System Innovation Plan (SHSIP), December 2015.

http://chfs.ky.gov/ohp/sim/. Accessed June 6, 2016.

[15] http://www.ssa.gov/OP_Home/ssact/title19/1915.htm. Accessed June 6, 2016.

http://www.ssa.gov/OP_Home/ssact/title19/1932.htm. Accessed June 6, 2016.

[16] 42 CFR Part 438.

[17] Centers for Medicare and Medicaid Services: http://medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/managed-care-site.html. Accessed June 6, 2016.

[18] National Academy for State Health Policy: http://www.nashp.org/resources-improve-medicaid-children-and-adolescents/. Accessed June 6, 2016.

[19] Consumer Assessment of Healthcare Providers and Systems (CAHPS) provided by the Agency for Healthcare Research and Quality; http://www.ahrq.gov/cahps/index.html. Accessed June 6, 2016.

[20] For the most recent protocols, refer to http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html. Accessed June 6, 2016.

[21] http://www.chfs.ky.gov/dms/pqomcoqbreports.htm. Accessed June 6, 2016.

[22] http://chfs.ky.gov/NR/rdonlyres/0197AE79-ED57-4D5E-AE9C-85E7713085A1/0/KY2015REPORTCARD81015.pdf Accessed June 6, 2016.

[23] Toppe, Kristine Thurston, National Committee for Quality Assurance. NCQA Medicaid Managed Care Toolkit 2012 Health Plan Accreditation Standards Effective July 1, 2012-June 30, 2013; Assistance for State Agencies in Using NCQA Accreditation for Medicaid Managed Care Oversight, March 2012.

[24] Stephanie Bates (DMS) and Carolyn Gallagher (IPRO). Evaluating Care Coordination for Medically Fragile Foster Children. CMS Quality Conference. December 2, 2015. Baltimore, Maryland.

[25] DMS website: http://www.chfs.ky.gov/NR/rdonlyres/776FEBA1-F0DA-4A5B-BD40-8EFC4B18D910/0/CopyofCMS_416_12_2010forFFY20153.pdf and http://www.chfs.ky.gov/NR/rdonlyres/59130D56-81EA-4757-84F1-3B4685E51BAA/0/FY2014CMS416.pdf. Accessed June 6, 2016.

[26] New York State Quality Strategy July 14, 2014 (Accessed June 6, 2016): http://www.health.ny.gov/health_care/managed_care/docs/quality_strategy.pdf.

[27] California Quality Strategy 2014 (Accessed June 6, 2016): http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Qual_Rpts/Studies_Quality_Strategy/MgdCareQualityStrategy2016.pdf.

[28] Florida Quality Strategy (Accessed June 6, 2016): http://ahca.myflorida.com/Medicaid/quality_mc/pdfs/Florida_Medicaid_Draft_Comprehensive_Quality_Strategy_2014_Update.pdf

[29] Maryland Quality Strategy HealthChoice Program 2012 – 2016 (Accessed June 6, 2016): https://mmcp.dhmh.maryland.gov/healthchoice/Documents/Maryland%20Medicaid%20Quality%20Strategy%202012-2016%20-%20Final%20Draft%20(06.01.2015).pdf

[30] New Jersey Quality Strategy (Updated June 12, 2014) Accessed June 6, 2016: http://www.nj.gov/humanservices/dmahs/home/MLTSS_Quality_Strategy-CMS.pdf

[31] The PDSA Cycle The W. Edwards Deming Institute, Copyright © 2015 at: https://www.deming.org/theman/theories/pdsacycle. Accessed June 6, 2016.

[32] AHRQ. Measure #46. Relational Coordination Survey (RCS): http://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/atlas2014/chapter6q.html. Accessed June 6,2016.

[33] Barlow SE. Expert committee recommendations regarding the prevention, assessment and treatment of child and adolescent overweight and obesity: summary report. Pediatrics 2007; 120:S164.

[34] New York State Quality Strategy July 14, 2014: http://www.health.ny.gov/health_care/managed_care/docs/quality_strategy.pdf

[35] California Quality Strategy 2014 (Accessed May 16, 2016): http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Qual_Rpts/Studies_Quality_Strategy/MgdCareQualityStrategy2016.pdf

[36] Florida Quality Strategy: http://ahca.myflorida.com/Medicaid/quality_mc/pdfs/Florida_Medicaid_Draft_Comprehensive_Quality_Strategy_2014_Update.pdf

[37] Maryland Quality Strategy HealthChoice Program 2012–2016: https://mmcp.dhmh.maryland.gov/healthchoice/Documents/Maryland%20Medicaid%20Quality%20Strategy%202012-2016%20-%20Final%20Draft%20(06.01.2015).pdf

[38] New Jersey Quality Strategy (Updated June 12, 2014): http://www.nj.gov/humanservices/dmahs/home/MLTSS_Quality_Strategy-CMS.pdf